Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1 Decedent's Name (First, Middle, Last) Day **Physician** 10:15 Robert Gamble James April 20. 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Days 1 🔀 M 2 🗆 F Director Jan. 18, 1933 | Michigan 369-32-2884 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10b. County ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Director Maryland Harford Bel Air 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 708 Glen Court 21015 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ∐Yes 2 ☑ No Specify: <u>ک</u> 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Civil Engineer Civil Engineering 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Health and Mental F tem 27 is marked of should be Arthur Edwin James Marian (nmn) Wilson ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 Ellen James / Wife 708 Glen Court, Bel Air, Maryland, 21015 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date P 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Hilltop Service Corp. 4/24/2009 Towson, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pulmonary Physician Weeks disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Nephropathy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed Due to (orgas a consequence of): burial-tran Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Vital Records, Completed by 1 🗌 Yes 2 ☐ Ho 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a Was an page 2 autopsy performed? Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 No 1 Anpatient 2 ER/Outpatient 3 DOA Medical Certification: To 1 ☐ Yes this Division of 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred the Hospital or Attending 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifi Chesapaake on who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 21, 2009 04:55a.M April Johnson Gisela Maria /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Knollwood Manor Nursing Home Millersville Anne Arundel Co. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Min 1 □ M 2**K** F July 2, 1927 452-46-1999 81 Germany Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 □Yes 2 □XNo Director Anne Arundel Co. Maryland Glen Burnie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21060 907 Sunnybrook Drive United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 27 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: White 2 Specify: 3 € Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Inspector Westinghouse Co. 12 yrs. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown Unknown Burgttraf ೭ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mr. Thomas Carr / Son 12 Kellington Drive Pasadena, Maryland 21122 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem. Park 04/25/2009 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Singleton Funeral & Cremation Services PA; 1 2nd Ave SW, Glen Burnie, MD 21061 M01121 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIOVASCULAR DISEASE ATHGROSCLEROTIC disease or condition resulting in death) YEARS Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months
1 Yes 2 No Day 5 Other (specify) 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA ျ Certification: 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier TX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29c. License number

D31(36

APRIL 21, 2009

KILBRIDE RD, BATIMORE, MD 2236 29b. Signature and title of certifier

Box 68760. attending physician certificate be the as use ō signed by the a Ö ٣. of Vital Records, has certificate Attending Physician: After this filled in by the funeral Division death. 24 hours after death e Funeral Director: ō Hospital To the Hosp within 24 hou To the Funer completely fil

Funeral

Director

28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If Medical Evantment provided any

Physician

/Medical

Examiner

and

Baltimore, Maryland 21215-0036

State Registrar

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BRIAN C-WALLACE; WW, 9005

	State of Maryland / Department of Headstree Certificate of De		2000	13003
	1. Decedent's Name (First, Middle, Last)	2. Date of		3. Time of Death
Physician /Medical	Frank Charles Joran Jr.	A PR	Day Year 200	9 04 12 PM
	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Lo	/ \ A C	4c. County of Dea	th
/	7	The Oly f Under 24 Hrs. 8. Date of	Baltimor	e City thplace (State or Foreign
Funeral Director		Hours Min. (Month,	Day, Year) C	yland
200	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
f show				1 ☐ Yes 2 🏗 No
death with the Maryland ems 23a or 28a-f show crives be notified at neral Director	MD Anne Arundel Linthicum 10e. Street and Number 10f. Zip Code	-	10g. Citizen of What C	ountry?
th with 23a o	534 Shipley Road 21090		USA	
Rer death w	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hisp	anic Origin? (Specify Yes or Mexican, Puerto Rican, etc.)	No- 14. Race - Ame Black, Whit	
N N N N N N N N N N N N N N N N N N N	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give 1 ☐ Yes 2 ☐ No S ☐ Wildowed 4 ☐ Divorced Year or Dates:	Specify:	Specify: W	hite
21215-0036 d within 72 hours aft glene. It than "natural", or it is all Exert.	15 Decedent's Education 16a Decedent's Usual Occupation	on	16b. Kind of Business	/Industry
21215-00 21215-00 ad within 72 hou ygiene. er than "natura t, in a "sile le	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Adminstrative C		Oil Compar	ıv
d 2.	12	B. Mother's Name (First, Midd	-	
yland yland huld be fil Mental H arked oth aric even	Francis C. Joran, Sr.	lary Schultz		
laryla 2 should to and Men is market aumatic	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and			Zip Code)
e, N e, I t and t ealth om 27 ther tr	Mrs. Jean B. Joran/Wife 534 Shipley Roa 20a. Method of Disposition (Name of	d, Linthicum,	MD 21090 20c. Location - City or	Town State
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Marylan once. To Be Completed by Funeral Director	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation '5 ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Atlantic Crematory	1	9 Glen Burni	
Balt permit. Depart Import any Inj	21. Signature of Funeral Service Ligensee 22. Name and Address of Services. PA	of Facility Singlets 1 2nd Ave.	n Funeral & W Glen Burni	Cremation e, MD 21061
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Jer Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			Choic Chaic
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8760, cate be executed physician and the burial-transit dical Examin	Due to (or as a consequence of):			
687 tifficate g phys as the	d			
Box 68 leath certific attending pl for use as t	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy		23d. Date of de	elivery Day Year
P.O. Box 6 nat the death certifit d by the attending etached for use as	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (specify)		-	bay rea.
ds, P.O. Lires that the de signed by the ad detached 1 by Physical	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in	in Part I. 23e. D	id tobacco use contribute t	o the cause of death?
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			erformed? death?	
of Vital Re Physician: The k this certificate ha ral director, page 2	examiner?	6. Place of Death (Check on		
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Vision of Attending Phyrogenesis. Sector: After this by the funeral filtration: T	1 Natural 5 Pending (Month, Day, Year) Injury Work?	s 2 🗆 No	be now injury occurred	
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Division Division to the Hospital or Attent within 24 hours after death To the Funeral Director. completely filled in by the Medical Certificat	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, 2 Medical Examiner: On the basis of examination and/or investigation, in my opin and manner stated.			
Nethin Somple	29b. Signature and title of certifier 29c. License no		29d. Date signed (Mon	
	D63	170	APR 20	, 2009
10x11	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SYED A RIZVI, MD Sinwi He	170	1 Baltim	re imp
State Registrar	31. Date filed (Month, Day, Year) APR 2 3 2009 32. Registrar's Signature	/		

DHMH 17 Rev 1/2001

State Registrar

DESCHL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

C.M

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)



4940

29c. License number

RES-

ASTERN AVENUE

000

29d. Date signed (Month. Day. Year)

APRIL 20

BALTIMORE

			For State Registrar	State of Ma	ryland		rtment of H tificate of L		-	glene Reg. No.	09	13005
ľ	Dhysici		1. Decedent's Name (First, Middle,	Last)					2. Date of Dea Month		Year	3. Time of Death
	Physicia /Medic		DANE	PAUL	KORI	NICK	41. O'lle Terre	Landian of Dooth	APRIL	20, 2009 4c. County of		6:00 P M
	Examin	er	4a. Facility Name (If not institution, 2608 CLAYTO)				JOPPA	Location of Death		HARF		
	Funeral			S. Sex 7. Age	(In yrs. las		If Under 1 Year Months Days		8. Date of Bird (Month, Da			lace (State or Foreign try)
	Director		217-50-4536	1 ½ M 2□ F	61	Yrs.	Monard Bays	110010	Sep. 2	4, 1947		sylvania
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation				10	Od. Inside City Limits
	Mary a-f sh	ctor	Maryland Harford	a	Jop	pa						1 ☐ Yes 2 No
	or 28	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of W	hat Count	ry?
	s 23a	eral	2608 Clayton I	la. Was Decedent E	vor in LLC	10.1	21085		pacify Vas or No	USA 14. Race	- Americ	an Indian
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5-0036	72 hours after death with the Maryland "natural", or items 23a or 28a-f show glost Experiment by northly of an	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give** Year or Dates:		1	∐Yes 2∐XNo	Specify:		Specify:	Wh	
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ylan	ould b Ment larked	2	Paul Harry Korr					Margare) Ference		
Zaz	d 2 sh th and 7 is m traum		19a. Informant's Name/Relationsh Victoria Korni				g Address (Street			•		Code)
	s 1 and of Health Item 27 other t		20a. Method of Disposition		20b. Pla	ce of Dispo	Clayton sition (Name of natory or other place	ROAQ, JO	ppa, Mai Date	20c. Location - 0	City or To	wn, State
Ē	Page nent c int: If iry or		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp	3 ☐ Removal from State ecify)	1		Service C	i	5-09	Towson,	Mary	vland_
Baltimore,	permit. Departr Importa any inju		21. Signature of Funeral Service L	icensee		22 Mc	Name and Address Fu	ss of Facility neral Ho	me, P.A			N. Antonio
ì			23a. Part1. Enter the disease, or o shock, or heart failure. List of	complications that caused	the death.	Do not ent	317 Cokes er the mode of dying	bury Roading, such as cardiac	or respiratory a	gdon, MD irrest,	2100	Approximate Interval Between
	Physician	, y	shock, or heart failure. List of Immediate Cause (Final disease or condition	nly one cause on each in			rcinor		nefo	itster		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a								
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o	The law requires that the death cert ate has been signed by the attending age 2 should be detached for use a	Physician/M	in the past 12 months? 1 □Yes 2 □No 9 □ Unknown	4 ☐ Pregnant at 9 ☐ Unknown			Other (specify)			Mor	101	Day Teal
J.	that the dended by the stacked to		Part II. Other significant conditio	ns contributing to death bu	ut not result	ing in the u	nderlying cause giv	en in Part I.	23e. Did t	tobacco use contr	ibute to th	ne cause of death?
rds	w requires to been signed should be a	ed by							1 🗆	Yes 2No	3☐ Prob	oably 4 Unknown
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0	Attending Physician: st death. ector: After this certific. by the funeral director, I	ΞŢ	27. Manner of Death	28a. Date of Inju	ry 2	28b. Time o			,	how injury occurre		7)
Sior	Attendin death. ctor: Af y the fur	catio	1 Natural 5 Pending 2 Accident investig 3 Suicide 6 Could n	ation			M 1 □	Yes 2 □ No				
Division of	for At after d Direct d in by	Certification: To	3 Suicide 6 Could n 4 Homicide determi		iry - At hom c. <i>(Specify)</i>	ne, tarm, str	eet, factory, office		City or To	Street and Numbe wn, State)	er or Hura	I Houle Nulliber,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		(Check only 2 Medical I	g Physician: To the best of Examiner: On the basis of	f examination	ledge, deat	h occurred at the ti	me, date and place	e, and due to the urred at the time	e cause(s) and ma , date and place, a	nner as s and due to	tated. the cause(s)
	o the l	Medical	one) 29b. Signature and title of contifier	and manner sta	ated.		29c. Licens	se number		29d. Date signed	(Month,	Day, Year)
1	->-0		1	PHT	SICI	EAN	Do	20584	75	APRIL	-21	,2009
	12~		30. Name and address of person	who completed cause of d	eath (Item 2	23a) (Type,						
	Sta	ate.	31. Date filed (Month, Day, Year)	TPUMIN 32. Registr	ar's Signatu	ire .	4TWOOD	COAD	BIEL	AIR	MD	21014
	Regist		APR 2 3 20	32. Registra	1.	par						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 19a, 26 per Th/verb., 1991; of Health and Mental Hygiene Certificate of Death Reg. No. For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Robert Joseph Krause 11:31pm [™] 2009 April 16 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carrol1 Carroll Hospital Center Westminster Birthplace (State or Foreign Country)
 MD If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept 23, 1947 Social Security Number 7. Age (In yrs. last birthday **Funeral** Days Hours Min 1 □ vM 2 □ F Sept 212-48-5563 61 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Eventual 1. Institute at once. 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location 1 ☐Yes 2√ No Director Carrol1 Westminster 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 4115 Teklen Drive 21157 USA Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: White <u>ک</u> 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Steamfitting <u>Steamfitter</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Walter Krause Magdalene Kruger ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print)
Sandra M. Krause
Mrs. Sandra Marie Krouse (Wife) 4115 Teklen Drive Westminster, MD 21157 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest Vet Cem. 4/23/09 Dwings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, P PO Box 195 Sykesville, MD 21784 21. Signature of Funeral Service Licensee tello M00764 23a. Part 1. Enter the disease, or complications that paused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical as a consequence of): Examiner ovenau Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the Hospital or Attending Physiclan: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Dav in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 ☐ Other (specify) 9 Unknown cate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performa certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 54 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA 1 ☐ Yes Certification: To this 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Aftert 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 0 27 2/1 29b. Signature and title of certifier 9

State Registrar

Registrar

31. Date filed (Month, Day,

mpleted cause of death (Hem 23a) (Type, Print)

MD 6/90 Geowse from bld. Eldersburg, MD 2/784

22. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Mason James Maddox **Physician** 2009 9:55 P.M 21, April, /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 10 Hampton Road If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, June 27, 1 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1**X** M 2□ F 219-49-3740 Maryland 11 Director Usual Residence of Decedent 10d Inside City Limits 10b. County 10c. City, Town or Location 10a State 28a-f show d other than "natural", or items 23a or 28a-f shovevent, the Medical Examiner must be notified at 1 ☐Yes 2 😾 No Director Anne Arundel Linthicum Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21090 U.S.A. 10 Hampton Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 ∐Yes 2 X No Black, White, etc. hours after 1 X Never Married 2 ☐ Married Maryland 21215-0036 1 □Yes 2X No Specify: Specify: White If Yes, Give Year or Dates \$ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) within 72 Elementary/Secondary (0-12) College (1-4or 5+) marked other than Student Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ould be f permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 Is marked any injury or other traumatic ew James Earl Maddox April Joy Cunnings 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) James E. Maddox / Father 10 Hampton Road, Linthicum Hights, Maryland, 21090 altimore, 20b. Place of Disposition (Name of cametery, crematory or other place)

Meadowridge Memorial 4/25/2009 20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Elkridge, Maryland 22. Name and Address of Facility Gary L . Kaufman Funeral Home, Inc. ure of Funeral Service 7250 Washington Boulevard, Elkridge, Maryland,21075 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lin. Immediate Cause (Final disease or condition resulting in death) **Physician** vear /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Erner underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed as the burial-tran Due to (or as a consequence of) P.O. Box 68760, Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a Was an autopsy performed? Yes 2 \(\overline{\Delta}\) No has 1 □ Yes Hospital or Attending Physician: filled in by the funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 \(\sum \) Nursing Home 1 Yes 2 No Hospital: 5 Residence 6 □ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA Certification: To this 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death after death. Injury 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 Homicide 24 hours a Let ifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Umbedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 ho

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State

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person who completed cause of death (Item 23a) (Type, Print)
Fried man, Mc 600 North Wolfe Street, BACTIMORG, Moryland 21287 31. Date filed (Month

Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

and manner stated

Registrar

29c. License number

0003.

29d. Date signed (Month, Day, Year)

09-03098

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	اِ	1- For State Registrar		Cer	tificate of	Health ar Death				eg. No.		UU.	7	1301
Physicia al Exami		Decedent's Name (First, Middle, Joshua Wilbur Mun							Date of Dea Month April 18, 2		Year	3	. Time of 0319 I	
)		4a. Facility Name (if not institution,		ımber)		4b. City, Town, o	r Location of		April 10, 2	40	. County of			
		8001 Muirkirk Road				Beltsville					Prince Ge			
Funeral			. Sex	7. Age (In yrs. Ia	ast birthday)	If Under 1 Ye Months Da		24Hrs. Min.	8. Date of Bi			Birthp Foreign	lace (Sta	ite or
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<u> </u>	ا۔	MD Prince	Georges		Bowie							1	Yes	2 X N
Aaryland 28a-f show 1 at once	Director	10e. Street and Number				10f. Zip Code				0g. Cit	izen of Wha	t Country	y?	
I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Ifem 27 is marked other than "natural", or items 23a or 28a-f she r traumatic event; the Medical Examiner must be notified at once		4216 Quanders Pro	mise Drive	2		2	0720				USA			
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or ite	E	1 X Never Married 2 Mar	1 Yes	2 X No				T GONO TO	0411, 010.7		Specify: A		n - Ame	rican
hours afte 'natural'', Examiner	<u>آھ</u>	Widowed 4 Divor Decedent's Education (Specification)	ced If Yes, Give Yes or Dates:			Yes 2 X N		ind of wo	rk done	16b.	Specify: * * Kind of Bus			LICII
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Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and lely filled in by the funeral director, page 2 should be detached for use as the burial – transit	ertification: To Be Completed by Physician/Medical	or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury and initiated events resulting in death). Last UNPENDED IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unkr Part II. Other significant condition 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendicular Pholicide 29a. Certifier 1 Certifying Pholicides	Due to (or as b. Due to (or as d. Due to	a consequence of outcome of presolution and at time of displaying the consequence of Injury - At it is consequenc	erFH G80 panacy 2 Fe panacy 2	26.Pla t 3 DOA Injury 28c. Ir 1 pet, factory, office	e given in Pa	(Check or Nursing ? Co. 28	23e. Did 1 Yu 24a. Wa: autr perf 1 Yes 24y Yes 28d. Describe 0ccupant: 28f. Location or Town, 001 Muirkir	Residuate (Street State) k Roa	Month Do use contril No 3 24b. W Do d No 1 dence 6 dence 6 dence object and Number dd, Beltsvill	Dabute to the Proba Were autorior to co eath? Yes Other: ed ect colliner or Rura e, MD as stated ue to the	bly 4 psy finding mpletion Scene Sion al Route finding cause(s)	of death? Unknowr Ings availab of cause of
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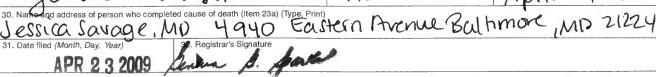
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Gloria April 23:21 PM J. Macks 21 2000 /Medical 4b. City, Town, or Location of Death

Bulhmore 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Tohns Hopkins Bayview Medical Cent Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🔀 F Days 68 220-36-6195 June 30,1940 West Virginia Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, "he Medical Examinar maist be motified at 1 ☐ Yes 2X No Dundalk Baltimore Director Md. 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? should be filed within 72 hours after death with USA 112 German Hill Road 21222 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 ∐Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White ፩ 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If ften 27 is marked other than "na any injury or other traumatic event and once. Elementary/Secondary (0-12) College (1-4or 5+) Aircraft Factory Worker 10 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Garnet Collins French W. Hylton ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shawnee Brooke Drive, Havre DeGrace Md. 21078 Niece Carolyn L. Holt 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition IX Burial 2 ☐ Cremation 3 ☐ Removal from State Halethorpe, Maryland 2009 Meadowridge Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, 7110 Sollers Point Road, Dundalk, 21. Signature of Fungral Service Licensee P.A. Md. 21222 23a. Part1. Enter the disease or complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Respirator Physician /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Myocardia burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Year Day Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed? 1 ☐ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🗓 🛚 🗷 0 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 1 Natural Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 5 Pending 1 ☐ Yes 2 ☐ No investigation 24 hours after death, Funeral Director: A 2 Accident filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a. Certifier 📉 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier rca savageme RES-000

State Registrar

31. Date filed (Month, Day, Year,



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** UNIVERSITY OF MARYLAND MEDILALLOWER BALTIMORE N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2\2 F Months Director MARYLAND MARCH 24 215-86-6951 Usual Residence of Decedent filed within 72 hours aftar death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Medical Examiner must be notified at 1XX es 2 □ No Funeral Director MARYLAND BALTIMORE N/A 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō or items 23a 942 BENNETT PLACE U.S.A. 21223 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 X Never Married 2 ☐ Married Baltimore. Maryland 21215-0036 1 ☐ Yes 2X No Specify. Completed by Specify: BLACK 3 Widowed 4 Divorced 'natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th grade CLOTHING CARE UPDATE LAUNDRY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any lipiny or other traumatic event once. Be NORMA JOYCE MAYER ၉ unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Davon Mayer/Son 1135 Ellicott Dr., Baltimore, Maryland 21216 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🗱 remation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY 04-23-09 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licens 22. Name and Address of Facility
WILLIAM C BROWN COMM FUNERAL HOME P.A. 1 rus 1206 W NORTH AVENUE Pod.) Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Part 1 Enter the disease, or Immediate Cause (Final **Physician** SEPSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner PNEVMONIA Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Aftar this certificate has been signed by the attending physician and funeral director, paga 2 should be detached for use as tha burial-transit or Attending Physician: The law raquires that the daath certificate be exacuted Division of Vital Records. P.O. Box 68760念 Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 🔲 Ectopic pregnancy in the past 12 mon 1 ☐ Yes 2 No 9 ☐ Unknown Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2. NVC 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident (Month, Day, Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No after death death the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

Registrar DHMH 17 Rev 1/2001

State

To the Hospital

29a. Certifier

29b. Signature and title of certifier

Medical

se of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 1 State of Maryland / Department of Health and Mental Hygiene 20b, c, 28b per fh/me, 8890, 04/23/09dhb Reg. No. 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death April **Physician** 2009 Pluma Beatrice Miller 08:48 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Center Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛚 F 1914 West Virginia 214-07-2098 94 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner invat be as diffed at 1 ☐ Yes 2 X No Director Maryland Harford Forest Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1716 Marning Brook Drive 21050 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: White þ 3X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife In the Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Oscar M. Keckley Daisy Shingelton ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kirk Katzenberger (Grandson) 1716 Marning Brook Drive, Forest Hill, Maryland 21050 20b. Place of Disposition (Name of cemetery, crematory or other place)

Scient Function

Evans Funeral Chapel

Belaix 04/09/09 Forest Hill, MD Paltimore, Maryland 20a. Method of Disposition 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services — Parkville
8800 Harford Rood, Parkville, Maryland 21234 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or healt i liure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) reexs **Physician** /Medical Due to or as a consequence of) Examiner Severe equalitially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed the burial-tra Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical attending p If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Dementis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performe certificate 1 □Yes 2 □No ours after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA Spece Certification: To 28b. Time of **UNK** 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 1 Natural 5 Pending investigation fall out of Bed MARCH 20, 2009 morningM 1 □Yes 2 🗹 No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital or 1813 Old Eastern Blud April 257, BAtto. Apartment e Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. the To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2 CHN

State Registrar 31. Date filed (Month, Day, Year) APR 23 2009

30. Name and address of person who completed cause of gleath (Item 23a) (Type, Print) W. A. Riley G. SMC (6701 N. Chard 32 Registrar's Signature rack

N. Charles St. Balto. Md 21207

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2009 Mary J. Moore **Physician** 19, 7:20 A M April /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Gilchrist Hospice Towson Baltimore 8. Date of Birth (Month, Day, Year) June 3, 1922 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) MD Country) **Funeral** Months Days Hours 1□ M XX F 86 Director 220-22-3378 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show ed other than "natural", or Items 23a or 28a-f show event, the Wedical Examinar must be notified at XXYes 2 □ No MD N/A Baltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 3009 Evergreen Road 21214 Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 72 hours after 1 ☐ Yes 2 ☐ XX If Yes, Give Year or Dates: XX Never Married 2 ☐ Married 10 Baltimore, Maryland 21215-0036 White 1 ∐Yes 2**X**No Specify: Specify: ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) St. Mary's Seminary Elementary/Secondary (0-12) College (1-4or 5+) Secretary 12 permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygid Important: If item 27 Is marked other any Injury or other traumatic event, III 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Thomas Moore Margaret Kathleen Gardner ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Hydes, MD 21082 Elizabeth Graf (Friend) 4511 Hydes Road 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 XX remation 3 ☐ Removal from State Atlantic Crematory 04/21/09 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, 3631 Falls Road Balto, MD 21211 21. Signature of Funeral Service Licen 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Demant ComplicaTrons **Physician** Alzhiner disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed and burial-trar Due to (or as a consequence of) Box 68760, attending physician Physician/Medical the as use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Por Day Year 5 ☐ Other (specify) detached 1 ☐Yes 2☐No P.0. 9 Unknown 9 Unknown signed by to be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 □Yes 2 → No 1 ☐Yes 2 ☐No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Weiple Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? Certification: Attending Injury 5 ☐ Pending investigation 1 □Yes 2 □No 2 ☐ Accident 6 □Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Ĵ V

State Registrar

31. Date filed (Month, Day, Year)

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene 2 0 0 1 3 0 1 3

C33C OWENS		1- For State Criticate of Department of The Certificate of Department of The			2 U U I j. No.	, 1001
Physicia	ın/	Registrar 1. Decedent's Name (First, Middle,Last)		Date of Death Month	Day Year	3. Time of Death
Aedical Exami		Jesse Owens	To a location of Double	March 7, 20	009	1825 hrs
.)			y, Town, or Location of Death attsville	1	4c. County of Death Prince George	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If L	Inder 1 Year If Under 24Hrs	8. Date of Birth	(MM/DD/YYYY) 9. Birl	hplace (State or
Director		220-63-7867 X M 2 F 54 Yrs.	inths Days Hours Min	08/01/	1954 Foreig	ⁿ ^{Intry)} Ghana
any	H	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
*	5	Maryland Prince Georges Hyattsville				1 Yes 2 No
Maryla	Director		Zip Code		g. Citizen of What Cour	ntry?
0036 within 72 hours after death with the Maryland yene. ner than "natural", or items 23a or 28a-f sho Medis. I.Ex. miner must be notified at once.			0784		Ghana	can Indian, Black,
eath wi	Funeral	1 Never Married 2 X Married Armed Forces? If Yes, sp	edent of Hispanic Origin? (Specify Cuban, Mexican, Puerto		White, etc.	carringian, black,
after de	P, F		2X No specify:		Specify: Bla	ack
hours :	ed b	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Using most of	ual Occupation (Give kind of working life. DO NOT use reti		16b. Kind of Business/l	ndustry
36 hin 72 e. than "	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 12 4 Reception	o i at		Daniet.	
5-0036 led within 72 Hygiene. other than '	S	17. Father's Name (First, Middle, Last)	18.Mother's Name	e (First, Middle, M	Registry aiden Surname)	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medi	Be	Kwabena Osei	Maame At	ttama		7.01
MD 2 d 2 should the and M and 27 is m aumatic	욘	11.2	ess (Street and Number or I		MD. 2073	
e, MD 1 and 2 sho Health and item 27 is	ŀ	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	iverdale Date	20c. Location - City or	Town, State
imore, MD 2 Pages 1 and 2 shounent of Health and I lant: If item 27 is root of or other traumatic		TX Dullat 2 Clettation 3 Removal non State	scopal Cem. Ap	pr.25,20	9 Forestv	ille, MD
Baltimore, permit. Pages 1 a Department of He Important: If ite	1	21. Signature of Funeral Service Liver see 22. Name a	and Address of Facility	endon/Hal	le Funeral	Hame
Physician		23a. Part I. Enter the disease or complications that caused the death. Do not enter the mo	Annapolis Rd. de of dying, such as cardiac c	or respiratory arres	st, shock, or heart	Approximate Interval
/Medical Examiner	1	failure. List only one cause on each line. Immediate Cause (Final disease a Ruptured bladder				Between Onset and Death
Xammor		or condition resulting in death) Due to (or as a consequence of):				
	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
0	Examiner	cause. Enter Underlying Cause (Uisease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				_
Transit transit	Ě	d				
'60, cate be executed physician and he burial - transit	Medical	UNPENDED				_
876 tificate ng phy as the t		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal deal	ath 3 Ectopic pregna	ancy	23d. Date of delivery Month	Day Year
Sox 687 leath certific e attending I for use as th	Physician/	1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown	Specify)			
D. B. It the de by the ached f	F.	Part II. Other significant conditions contributing to death but not resulting in the underly	ying cause given in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
, P.C res that signed be det	d b	Prostatic hypertrophy		1 Yes	2 No 3 Prob	oably 4 Unknown
ords,	Completed by			24a. Was a autops	y prior to d	topsy findings available completion of cause of
Recc The lay cate ha	E O			perform 1 Y Yes 2		es 2 No
Vital Rec ysician: The l his certificate l	Be	25. Was case referred to medical examiner? Hospital: 4 Inpution: 2 EP/Outputient 3	26.Place of Death (Check			
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ion of \text{tending Ph}; eath. tor: After title funeral	ţi	1 V Natural 5 Pending (Month, Day, Year)	1 Yes 2 No		• •	
ViSicor Atter der Director in by t	ifica	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, fac	tory, office building, etc.	28f. Location (Stor Town, St.	treet and Number or Ru	ral Route Number, City
Di spital tours a neral I	Certification:	4 Homicide determined (Specify)				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be execut within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - tran	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in				
To viii	ğ	29b. Signature and title of certifier	29c. License number		29d. Date signed (Moi	nth, Day, Year)
		(California)	O.C.M.E.		March 8, 2009	
3		Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Stre	eet, Baltimore, MD 212	201		
444	ate			-01		
Regis		31. Date filed Month Day 2009 Server 32. Registrary Signature				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Mary 1389 Separtment 89 Health 3/18 Mental Hygiene 1 - For State Registrar Reg. No. 2 Certificate of Death 2. Date of Death 1 Decedent's Name (First Middle Last) **Physician** 200 Fahim Suleiman Rabie /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Georges Prince Georges Hospital Cheverly Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Hours Months 1 □X M 2 □ F Nov. 15, 1958 Palestine Director 356-54-6266 50 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show ral", or items 23a or 28a-f shore Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Charles Indian Head 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with Funeral 4995 Strauss Avenue 20640 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 M∑No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 N Married , or Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: White \$ 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, Ir.e. Mangones. Furniture Retail 12 Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Meladeh Ibrahim Rabie Suleiman Mousa Rabie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4995 Strauss Avenue, Indian Head, MD 20640 Sharon Carlin Rabie - wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XI Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Trinity Memorial Gardens : 4/14/2009 Waldorf, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fleck Funeral Home, INC. MO1234 7601 Sandy Spring Rd., Laurel, MD 20707 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Fatal arrythmia /Medical Due to (or as a consequence of Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Sepsis 24a. Was an perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2 □ No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred / e// v ff Time or Injury 0 9 90 equipment, struck Lead 1 □ Natural 5 Pending investigation chonary 23 1XXYes 2⊟No 2 Accident 3 Suicide after death | Director: / d in by the f 2007 6 ☐ Could not be 28e. Place of Injury - At I ome, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1,00 (edac/V/// 4 Homicide n 24 hours the Funeral Dire Road Brandy wire, Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated within 2 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar Cheverly

who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month 20 Day 2009 10:05 **Physician** APRIL ELIZABETH FLORENCE SHAFFER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner TIAR FORD BELAIR KEALTH AND REMABILITATION CENTER BELHIR If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Hours 1 □ M 2 🔀 F 215-16-9353 87 1. 1922 Virginia Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Harford Bel Air 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21014 Funeral 20 Eastern Ave 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11 Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2√2 No Maryland 21215-0036 Specify þ 3 Widowed 4 □ Divorced White Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical al Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) Waitress Restaurant (unk) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be pe it of Health and Mental Hattie (nmn) Randall Carl S. Hartman or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20 Eastern Ave., Bel Air. MD Lois E. Golding / Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 Surial 2 □ Cremation 3 □ Removal from State permit. Page Department or important: If any Injury or Hilltop Service Corp. 4-24-09 Towson, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility
McComas Funeral Home, P.A. 21. Signature of Funeral Service Licenses Mul 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Ent. r the disease, or complication. hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Arteriosclerotic Heart Disease Sequentially list conditions. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner be executed burial-tran Due to (or as a consequence of): physician Physician/Medical as IF FEMALE nse 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal death 3 □Ectopic pregnancy Month Day Year for in the past 12 months? 5 ☐ Other (specify) 4☐Pregnant at time of death 1 ☐Yes 2 ☐ No P.0. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I Records, þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an has e 2 s autopsy page certificate I 1⊟ Yes 2121No Vital 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 20 No 4☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 1 🔲 Inpatient or 27. Many er of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Division (Month, Day Year) or Attending Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after death Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier d cause of death (Item 23a) (Type, Print) 30. Name and address of person who comp anuel 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

SHAFFER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** William David Stone Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 **X**M 2 ☐ F Director 220-07-9612 1920 South Carolina 88 Sep. 25, Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show Examiner must be notified at 1 ☐ Yes 2√ No Director Marvland Harford Bel Air 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with ō or items 23a 1108 Spalding Drive Unit M 21014 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. illed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Completed by 3 XWidowed 4 ☐ Divorced "naturai", White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8 Owner / Operator Retail Grocery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 James Frank Stone Mary Elizabeth Cross 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) es 1 and 2 sof Health an item 27 is William D. Stone, Jr. Son 1108 Spalding Drive Unit M, Bel Air, MD 21014 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of I-Important: If ite any injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemeterv 4-23-09 Baltimore, Maryland McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, 21. Signature of Funeral Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. d oronar Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) tone, William し Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) been signed by the a should be detached to 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Un (alun Atnal 2**₩**No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Injury 5 Pending investigation To the Hospital or Attendil within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ SuicIde Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Quertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 4/21/09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Kamman Muham M HOC Kevalulus St Howrede Graum 2478 Kammaly

Registrar

State

31. Date filed (Month, Day, Year)

APR 23 2009

DHMH 17 Rev 1/2001

2. Registrar's Signature

amend #2 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deat 20 April 2009 **Physician** Opa1 Virginia Scherer 5:00 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 690 Mesquite Road Severn Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Min 216-22-4950 1 □ M 2 🖾 F Months Days 94 **Director** Aug. 14, 1914 West Virginia Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Exeminar traust by in filled at 1 ☐ Yes 2 No Director MD Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with Hygiene. 690 Mesquite Road 21144 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White 2 3K Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+ Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event 17. Father's Name (First, Middle, Last) Be James Meadows Molley Jones ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Donald Scherer/Son 690 Mesquite Road Severn MD 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition April 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2009 Glen Burnie, MD 22. Name and Address of Facility Singleton Funeral & Cremation of Funeral S The Libensee 101226 Servcies.PA 1 2nd Ave. SW Glen BUrnie. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Year /Medical Que to (o as a consequence of): Examiner event a Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the death certificate be executed and burial-trar Due to (or as a consequence of): Box 68760 attending physician Physician/Medical the as IF FEMALE: nse yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Po in the past 12 months Month Day Year Pregnant at time of death 5 Other (specify) P.0. ☐Yes 2☐No the detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ð þ 1 Yes 2 1 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 1 24a. Was an page 2 s has autopsy performed certificate 2 ANO 1 ☐ Yes Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 **UN** 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ this 27. Manner of Death 1 Matural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Division 5 Pending investigation death. 1 □Yes 2 □No To the Hospital or Attend within 24 hours after death To the Funeral Director: 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 09 and address of person who completed cause of death (Item 23a) (Type, Print) John 31. Date filed (Month, Day, Year) 32. Registrar's S State 23 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician April 20, 2009 10:48A M David Mark Strecker /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8313 Loch Raven Blvd. #B1 Baltimore Baltimore 6. Sex 1 → M 2 → F If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, NOV 18, Birthplace (State or Foreign
Country) **Funeral** Months Days Hours 214-84-4749 41 Maryland Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ed other than "natural", or items 23a or 28a-f show event, the Medical Evan Ingr must be notified at 1 ☐Yes 2 No Director Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 8313 Loch Raven Blvd. #B1 21234 Funeral death 1 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 X No
If Yes, Give
Year or Dates: filed within 72 hours after 1 X Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐Yes 2 ☐XNo Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Electrical Warehouse Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be f nent of Health and Mental is marked o Russell Theodore Strecker Geraldine Alberta Pater 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau 13208 Dulaney Valley Rd. Glenarm, MD 21057 Denise Miller/sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State W. Arundel Crematory 04/22/09 Odenton, MD 4 Donation 5 DOther (Specify) 21. Signature of Funeral Service License Common Homes Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final or hythmis **Physician** cordiac 2 min you resulting in death) /Medical Due to (or as a consequence of): Examiner 2 neally Due to (or as a consequal ce of) crteny discos Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) P.0. 1 ☐ Yes 2 ☐ No 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 🗖 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 XYes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 ☐ Pending 1 ☐ Yes 2 ☐ No 2 TAccident investigation 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier horse-d DO020604 4/20/09 Kichende Ber 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Richard A. Bers. aD; Svite 450; 10755 Fells Road; Luthenile, Nd 21083 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

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APRIL	Baltimore, Maryland 21215-0036	permit. Fages I and 2 should be lied within 72 hours and Department of Health and Mental Hygiens in Important: If lem 27 is marked other than "natural", or any injury or other traumatic event, If a fundion Exactions.		4 ☐ Donation	5 ☐ Other (Speci	fy)		uid Ride	_		es of Fac							
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	ion	tending leath. tor: Aft the fun	atio	1 Natural 2 Accident	5 Pending investigation	on	Day, rear)	Injury	М	1 🗆	Yes 2	□No						
	ivis	or Attendate death Director:	Certification: To	3 ☐ Suicide 4 ☐ Homicide	6 Could not i determined	200. Flace of	Injury - At he etc. <i>(Speci</i>	ome, farm, st	reet, factor	y, office		1	28f. Location City or To	(Street a wn, Sta	and Numbe te)	er or Rura	l Route Numb	er,
		pura a ours a eral D filled i		29a. Certifier	1□ Certifying P	hysician: To the be	est of my kno	owledge dea	th occurred	at the t	ime, date	and place.	and due to the	e cause	(s) and ma	inner as s	tated.	
	2	one hospital or Atta within 24 hours after de To the Funeral Direct completely filled in by th	Medical	BNULSE	2 Modical Eva	miner: On the basis	e of avamins	ation and/or i	nvestigatio	n, in m y	opinion,	death occurr	ed at the time	, date a	nd place, a	and due to	the cause(s)	
	Ę	vithir To th comp	Me	29b. Signature an		4			29	c. Licen:	se numbe	er		29d. D	ate signed	(Month,	Day, Year)	
		. [2451M	2 SCHN	1			KI	497	192		4	1211	200	9	
		H .	1	30. Name and add		completed cause of	of death (Iter	m 23a) (Type,	Print)	1/1	L	RD -	IMONI	(1 K)	l ul) 2	11192	
		Sta	ato_	31. Date filed (Mo	onth, Day, Year)	32. Regi	strar's Signa	MICANO	-4 V/	74	-7	アン	1 1/40/41	u/	1 / (!		100	-
		Registr		APR	2 3 2009	Serena	13. 1	gara										

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 10:33 P.M 21. 2009 April Edgar William Thibou /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore County 11 A Brook Farm Court Perry Hall If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 M 2 □ F March 22,1912 Baltimore, MD Director 220-09-2193 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it. M. dical Extr. Incr., until b. netified at once. 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 ☐ Yes 217 No Director Maryland Baltimore County Perry Hall 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21128 United States Funeral A Brook Farm Court 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 1 No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ∐Yes 2 ☑No Specify Specify: þ White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Owner Tavern 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edgar Leonard Thibou Elizabeth Kernan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 30022 Mrs. Jo E. Cronin (Daughter) 3875 Redcoat Way Alpharetta, GA. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Aprií 1 ☐ Burial 24 ☐ Cremation 3 ☐ Removal from State Evans Funeral Chapel Forest Hill, Maryland 2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Peace Tul Alternatives Funeral & Cremation Ctr., P.A. 2325 York Road Timonium, Maryland 21093 23a. Part 1. Enter the disease, or complications that gaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause or leach line. Approximate Interval Between Onset and Death Physician pertensive heart disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last he law requires that the death certificate be executed and attending physician and for use as the burial-trai Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an e has autopsy performed? certificale Ď. Hospital or Attending Physician; 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Mil 22, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) igital Swite G Linthicum, MD 21090 31. Date filed (Month, Day, 2. Registrar's Signature Year) State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 U U 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2009 April 4:05 MAE VARNADO /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S LANHAM DOCTORS COMMUNITY HOSPITAL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday Date of Birth (Month, Day) **Funeral** Year) Days Hours Min 1 □ M 2 🖾 F 89 1919 Louisiana Director 438-14-5029 Nov. 13, Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Examinations to be notified at X Yes 2 □ No Director Maryland Prince George's Capital Heights 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 504 Shady Glen Drive 20743 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 No Maryland 21215-0036 1 ☐ Yes 2 ☑ No BLACK Specify: þ 3 ☑ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) STATE GOVERNMENT 12 FOOD SERVICE WORKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MALONSON ပ DORA TALMORE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 504 SHADY GLEN DRIVE, Capital Heights, MD.20743 GWENDOLYN KELLY-Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/24/2009 Clinton, Maryland Ressurection 21. Signature of Funeral Service Licery 22. Name and Address of FacilityPope Funeral Homes, P.A. 5538 Marlboro Pike Forestville, Maryland 20747 23a. Part 1. Inter the disease, o conshock, or heart failure. List only complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner 760 Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last SEPT requires that the death certificate be executed burial-transit and Due to (or as a consequence of) attending physician for use as the buria Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No Month Dav Year 5 ☐ Other (specify) P.0. ed by the a 9 Unknown signed | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ۾ 2 No 3 Probably 4 Unknown 1 Tes Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ∐Yes 2 ⊠No 2 No 1 ☐ Yes Division of Vital Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2. No 1∐ Yes 1X Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After t 1. Natural 5 Pending n 24 hours after death.

Re Funeral Director: Af 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🗺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MUD5818Z 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Hanover Parkway, Suite 101A, Greenhett, MD. 20770 D. George, MDA

State Registrar

Marley Neck Realth & Rehabilitation Glen Burnie A. County of Death Anne Arundel Social Security Number 6.5 ex. 7.7 age (in yras last birthous) Hursdey 1948 B. Date of Service 100. County 100. City, Town or Location 100. State 100. County 100. City, Town or Location 100. State 100. County 100. City, Town or Location 100. State 100. County 100. City, Town or Location 100. State 100. County 100. City, Town or Location 100. City, Town or		1	For State Registrar	State of Ma	aryianu		tificate of	lealth and N Death		Reg. No.	2009	1302
Marley Neck Realth & Rehabilitation Committee Com						Wa	lter		Month		.009 Year	3. Time of Death 1:20 A.M
The content of the	Examiner Funeral	1 5	Marley Neck Health 5. Social Security Number 6. S	n & Rehabi	e (In yrs. last	birthday)	Glen Bu:	rnie	8. Date of Bir	An	ne Arun	place (State or Foreig
18. Mother's Name (First, Micsie, Last) Melvin Walter 180. Mailing Address (Stimet and Number or Name Relationship (Type Frint) 181. Informant's NameRelationship (Type Frint) 180. Mailing Address (Stimet and Number or Name Relationship (Type Frint) 180. Mailing Address (Stimet and Number or Name Relationship (Type Frint) 180. Mailing Address (Stimet and Number or Name Relationship (Type Frint) 180. Mailing Address (Stimet and Number or Name Relationship (Type Frint) 180. Mailing Address (Stimet and Number or Name Relationship (Type Frint) 180. Mailing Address (Stimet and Number or Name Relationship (Type Frint) 180. Mailing Address (Stimet and Number or Name Relationship (Type Frint) 180. Mailing Address (Stimet and Number or Name Relationship (Type Frint) 180. Mailing Address (Stimet and Number or Name Relationship (Type Frint) 180. Mailing Address (Stimet and Number or Name Relationship (Type Frint) 180. Mailing Address (Stimet and Number or Name Relationship (Type Frint) 180. Mailing Address (Stimet and Number or Name Relationship (Type Frint) 180. Mailing Address (Stimet and Number or Name Relationship (Type Frint) 180. Mailing Address (Stimet and Number or Name Relationship (Type Frint) 180. Mailing Address (Stimet and Number or Name Address (Stimet And Number or Name Relationship (Type Frint) 180. Mailing Address (Stimet And Number or Name Addres		1	Usual Residence of Decedent 10a. State 10b. County	12	10c. City, T	own or Lo			JAN.16	,1934		Od. Inside City Limits
18. Mother's Name (First, Micsie, Last) Melvin Walter 180. Mailing Address (Stimet and Number or Name Relationship (Type Frint) 181. Informant's NameRelationship (Type Frint) 180. Mailing Address (Stimet and Number or Name Relationship (Type Frint) 180. Mailing Address (Stimet and Number or Name Relationship (Type Frint) 180. Mailing Address (Stimet and Number or Name Relationship (Type Frint) 180. Mailing Address (Stimet and Number or Name Relationship (Type Frint) 180. Mailing Address (Stimet and Number or Name Relationship (Type Frint) 180. Mailing Address (Stimet and Number or Name Relationship (Type Frint) 180. Mailing Address (Stimet and Number or Name Relationship (Type Frint) 180. Mailing Address (Stimet and Number or Name Relationship (Type Frint) 180. Mailing Address (Stimet and Number or Name Relationship (Type Frint) 180. Mailing Address (Stimet and Number or Name Relationship (Type Frint) 180. Mailing Address (Stimet and Number or Name Relationship (Type Frint) 180. Mailing Address (Stimet and Number or Name Relationship (Type Frint) 180. Mailing Address (Stimet and Number or Name Relationship (Type Frint) 180. Mailing Address (Stimet and Number or Name Relationship (Type Frint) 180. Mailing Address (Stimet and Number or Name Address (Stimet And Number or Name Relationship (Type Frint) 180. Mailing Address (Stimet And Number or Name Addres	s 23a or 28a	מומו חופר	10e. Street and Number 238 Allwood Drive				10f. Zip Code 21061	dianania Origina (Sc	posity Vos or No	U.S.	Α.	
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18. Mother's Name (First, Michigo, Last) 18. Mother's Name (First, Michigo, Last) 18. Mother's Name (First, Michigo, Mary) 18. Mother's Name (Firs	/grene. er than "nate i, tre Medica		(Specify only highest gra	de completed)	5+)	(Give life. [kind of work done OO NOT use retire	during most of work d) uperinten	dant	Petr	oleum t	ŕ
Patricia Moran (daughter) 20a. Neglaco d Disposition (America) 20b. Neglaco d Disposition (America) 20c. Location - City or Town, State (America) 20c. Location -	even de ort	2 _	Melvin					Margar	et		Trip	
23a. Part I. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval between Onset and Death Immediate Cause (Final death) 1	of nearing and filem 27 is in other traum		Patricia Moran (da	aughter)		3315	Jumpers	Hole Rd.	Apt. A.	,Mill	ersvill	e, MD.211
23a Part I. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, introval between Onset and Death Immediate Cause (Final death) Immediate Cau	Important: I any injury o once.	Ì	4 ☐ Donation 5 ☐ Other (Specify	<i>'</i>)	Meado	Ĝ.	a Yame and Adr	auffally Fu	neral H	ome@M	eadowri	dge Mem.
FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Ves 2 No 9 Unknown 1 Use birth 2 Fetal death 5 Other (specify) 23d. Date of delivery Month Day Year 2 No 9 Unknown 2 No Northing to completion of cause of death? Northing to completion of cause of death? 1 Northing to completio	ledical aminer pue un pue un pue un pue un pue un pue un pue un pue un pue un pue un pue un pue un pue un pue un pue un pue un pue un p	LYG	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if an, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as	a consequer	Ance of):	ry the mode of dy	ng, such as cardiac	or respiratory a	arrest,		Interval Between
Second S	the attending p	ysicialiymed	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal de	eath 3		су		2:		•
Second S	an signed by	2		6		ng in the u	nderlying cause gi	ven in Part I.				1.0
28a. Date of Injury - At home, farm, street, factory, office 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year)	page 2		25. Was case referred to medical					OC Pierre of Door	auto perfe 1 □Yes	psy ormed? 2 No	prior to co death?	impletion of cause of
29a. Certifier (Check only one) 29a. Signature and title of certifier and manner stated. 29b. Signature and title of certifier (Month, Day, Year)	fter this neral di	2	examiner? 1 Yes 2 No 27. Magner of Death 1 Natural 5 Pending investigation 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Da	ury ay, Year) 28 jury - At home	8b. Time of Injury	M 1 E	her: Nursing H iry at rk?	ome 5 Res 28d. Describe	idence 6 how injury	occurred	
D57028 04-20-09	he Funeral pletely filled	edical	(Check only 2 Medical Exam	niner: On the basis o	of examinatio	edge, deat n and/or in	h occurred at the vestigation, in my	time, date and place opinion, death occu	e, and due to the irred at the time	e cause(s) , date and	and manner as s place, and due t	stated. o the cause(s)
55. Thaile and addition of person title completed dates of death from many (1995) I tilly	To the company of the	A	· A	completed cause of	death (Item 2	3a) (Tyne	I					

Please Type or Print in Black Indelible Ink., Ensure All Copies Are Legible. Shate of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** Whitted -4dell 04 3-2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BAZTIMENT, MAY (AM) 4120 West Forest Park Avenue 1st Floor Apt. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye S-24-192 9. Birthplace Country) 5. Social Security Number 7. Age (In yrs. last birthday) State or Foreign 6. Sex **Funeral** Days Min. 1 □ M 2 1 F Hours 225-32-7358 81 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at n/a Baltimore t Yes 2 No MD Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21207 4120 West Forest Park Avenue, 1st flr. Apt Completed by Furieral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, Black, White, etc. Specify: African-American 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2XNo Specify. If Yes, Give Year or Dates: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within th and Mental Hygiene. 7 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) T &TA 12th Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ollie Mae Stewart Thomas Jackson Pages 1 and 2 should be nent of Health and Men ဂ္ other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10653 Kings Mill Drive, Carmel, Indiana 46032 Important: If item 27 i India Anderson 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park Woodlawn, MD 4-21-09 22. Name and Address of Facility Wylie Funeral Time P.A. of 371 Limoto Co. na Pre of Funeral Service Licenses 9200 Liberty Road, Randallstown, MD 21133 Approximate Interval Between Onset and Death raft 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ADV ANCED **Physician** 4Pa-5 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to lor as a conse uence of Hospital or Attending Physician; The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760, the use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month for Day Year 5 Other (specify) P.O. ed by the a detached f 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ DECUBITIS 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy performed this certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 1 ☐ Yes 2000 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) Certification: To within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27 Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title 100/6561 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21000 S Ruhl Rd. Freeland, MD 21053 Registra State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Charles C. Widzga, Sr. 2009 40ri /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** N/A Baltimor ot Agnes Hospita 6. Sex 14 M 2 □ F 8. Date of Birth Dec. 21, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security umber (In yrs last birthday) **Funeral** ^{Yea}1938 Days Months unknown 216-34-4111 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" -- " any injury or other traumatic everal." 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 □Yes 2 No Maryland Baltimore Lansdowne Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 929 Winsap Court 21227 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces2 1 ☐ Yes 2 ☐ No If Yes, Give Ye ar or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No White Specify: Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary Secondary (0-12) College (1-4or 5+) Laborer Hotel 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be unknown unknown မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ^{19a.} Informant's Name/Relationship *(Type. Print)* Rosa Ferres, friend 926 Winsap Court Baltimore, MD. Date 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Atlantic Crematory 04-19-2009 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundral Service Licensee Ambrose funeral Home, Inc. Leke 1328 Sulphur Spring Rd. 21227 Approximate Interval Between Onset and Death Arbutus, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Respiratory **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner UNKNOWN avanoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner 5ep5i 5

Due to (or as a consequence of): requires that the death certificate be executed and burial-tra Box 68760. physician Physician/Medical the as attending properties of the second IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Records, P.O. detached 9 Unknown cate has been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe certificate | 1 □Yes 2 WNo 1 ☐ Yes 2 ☐ No Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner's Hospital: Other: 4 \sum Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Many er of Death 1 V Natural Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

within 24 hours after death. To the Funeral Director: A Hospital

> State Registrar

completely

Medical

29a. Certifier

(Check only

29b. Signature and title of certifier

and manner stated.

w

29c. License number 1)0061765 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

QUAINOD WICKERS AVE #307 wes 3350

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 9:30 16,2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** DOCTORS HOSPITAL Lanham Prince George's If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 1/28/1948 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2**X** F Director Washington, DC 578-66-9256 61 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Mudical Examiner must be notified at 1⊠Yes 2 No Director Maryland Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 23a 402 Hill Road 20785 Funeral United States "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces?

1
Yes 2
No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No 2 If Yes, Give Year or Dates: Specify: Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "na any linJury or other traumatic event, If a Mediconce. College (1-4or 5+) Elementary/Secondary (0-12) 12 Transportation Specialist Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Omia Yates ပ္ Rufus Chisley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 402 Hill Rd. Hyattsville, Maryland 20785 Aaron C. Walton / Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/29/2009 Maryland Veterans Cheltenham, Maryland 22. Name and Address of FacilityPope Funeral Homes, P.A. 21. Signature of Funeral Service License ance 401085 5538 Marlboro Pike Forestville, Maryland 20747 23a. Part f. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death CANCER Immediate Cause (Final disease or condition resulting in death) BREAST **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🔀 No Month Vear Day 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 万No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? certificate has birector, page 2 s 1 ☐ Yes 2 ☐ No 1 ∐Yes 2 X No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After thi funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

within 24 hours after death

To the Funeral Director:
completely filled in by the f

n.Bbdella 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

29d. Date signed (Month, Day, Year)

MUKEMUI Abdella, MP

122200 ANNAPOUS KOAD SUITE 229 GLENNAALE, MO

State Registrar 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier

Medical

32 Registrar's Signature

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#5,6perINF#23ptIIperPHYS,G891,5/5/09,WS

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 12:36 P^M DELORIS LEA WHITNEY 4/21/2009 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death HOLY CROSS HOSPITAL SILVER SPRING MONTOGOMERY Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In vrs. last birthday) **€**M 2**X** F Months Days Hours 577-60-62 5/31/1946 Washington, DC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 TyYes 2 □ No Maryland Prince George's Capitol Heights 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7818 Beechnut Road 20743 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 14 Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 🛣 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐No Specify: Specify: B1ack 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Computer Specialist U. S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Zelma Gwynn David Lea Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roosevelt Whitney Sr. / Husband 7818 Beechnut Rd. Capitol Heights, Maryland 20743 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ➡Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harmony memorial 5/1/2009 Landover, Maryland 21. Signature of Funeral Service Licen 22. Name and Address of FacilityPope Funeral Homes, P.A. 5538 Marlboro Pike Forestville, Maryland 20747 701055 23a. Part 1 Anter the disease or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) LEPTOMENINGEAL CARCINOMATOSIS Due to (or as a consequence of): BREAST CANCER Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 □Yes 2 🖸 No 9 Unknowi 23e. Did tobacco use contribute to the cause of death? Pagt II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. LYNS-CANCER 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2□No 1 ☐ Yes 2X No 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 ER/Outpatient 3 DOA 1x Inpatient 27, Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 🔲 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Examiner Physician: The law requires that the death certificate be executed burial-trans and physician s the burial Box 68760, SS attending properties as signed by the a Division of Vital Records, P.O. certificate this I or Attending Fafter death. Hospital Funera

Physician

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Pages 1 and 2 should

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Department of Health as
Important: If Item 27 Is
any injury or other trau

Physician

/Medical

Saltimore, Maryland 21215-0036

?7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modical Examination is set by notified as

/Medical

Director

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Physician/Medical

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Completed

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Sertification: To

cate has been signated by page 2 should by director, Director: After this in by the funeral ed in by

	ical			curred at the time, date and place, and due to t tigation, in my opinion, death occurred at the tim	
	Medi	29b. Signature and title of certifier	8 /	29c. License number	29d. Date signed (Month, Day, Year)
			MD	D 52503	4/21/2009
		30. Name and address of person who cor	mpleted cause of death (Item 23a) (Type, Prin	t)	
		SHAILESH SHETH MD	1500 Forest Glen Roa	ad Silver Spring, Mary	land 20910
Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature		
jistr	ar	APR 2 3 2009	Derver A back	1	
v 1/2	001		January January		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year $\underline{\textbf{A}}^{\mathsf{M}}$ Physician 21, 4:30 2009 DeWitt Waddell Warfield April /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Greater Baltimore Medical Center Towson If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** 1 M 2 □ F 218-92-1515 Oct.18,1961 Baltimore, MD. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 28a-f shov 7 is marked other than "natural", or items 23a or 28a-f shot traumatic event, the Medical Examiner must be motified at 1 ☐ Yes 2 No Directo Maryland Baltimore County Cockeysville Baltimore, Maryland 21215-0036 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number United States 21030 Apt.B 1037 Misty Lynn Circle Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: White Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) nt of Health and Mental Hygiene.
If item 27 is marked other than or other traumatic event, the M Home Improv. Supplies Salesman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dickens Waddell, Ph.D. H. Branch Warfield 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) (Parents) Apt.V-3 13801 York Road Cockeysville,MD 21030 Mr.&Mrs. H. Branch Warfield April 2009 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any Injury or once. Evans Funeral Chapel Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Peaceful Alternatives Funeral&Cremation Ctr.,P.A. 2325 York Road Timonium, Maryland 21093 21. Signature of Fune al Service License aur, 23a. Part1. Enter the riseast or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoc, in high art failure. List only one cause on each line. Approximate Interval Between Onset and Death Probable 14ocardial **Physician** Minutes disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Exami physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) 9 HInknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Unknown pneumonia Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an as e 2 s autopsy 1 □Yes 2 1 ☐ Yes 2 ☐ No this certific al director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Natural 2 ☐ Accident 5 Pending investigation 1 ☐Yes 2 ☐No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

State Registrar

31. Date filed (Month, Day, Year)

29a. Certifier

(Check only one)

29b. Signature and title of certifie



and manner stated.

N Charles St PPE 203

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D0051926

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Day Ye aı **Physician** 2009 April 2:46 Arthur Lee Whitt /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore City 5306 Mayview Avenue N/A If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days 1 ☑ M 2 ☐ F 213-62-3896 Balt., Maryland Director 8/22/1955 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show MXYes 2 □ No Director Maryland Baltimore Baltimore 10g. Citizen of What Country? United States of Austrica 10e. Street and Number within 72 hours after death with 21206 5306 Mayview Avenue America Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? "natural", or items 11. Marital Status 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black \$ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 Is marked other than "r Home Elementary/Secondary (0-12) College (1-4or 5+) Awning Installer Improvement permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clifford Farmer Helen Whitt ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mrs. Pamela S. Whitt/ wife 3922 Elmora Avenue Baltimore, Maryland 21213 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date April 27, 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery 2009 4 Donation 5 Dother (Specify) Parkville, Maryland 22. Name and Address of Facility Peaceful Alternatives Funeral & Cremation Ctr., P.A. 21. Signature of Fuheral Service Licensee 2325 York Road Timonium, Maryland 21093 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) pancicalic Cancel **Physician** 11/2002 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a ponsequence of) Examine the death certificate be executed physician and the burial-trans Due to (or as a consequence of): Box 68760 attending physician Physician/Medical as nse 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy for Day 5 Other (specify) P.O. ☐Yes 2☐No cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 No certificate e Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To sompletely filled in by the funeral 27. Manner of Death 1. Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical To the within 2 and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 153070 arein MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Offeens 159/hmore mD 212 32. Registrar's Signature 31. Date filed (Month, Day, Year) APR 2 3 2009 State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 009 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 6, 2009 Aitken Richard 11:40A April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 10001 Carter Road Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**⊠**M 2□F 316-32-4538 Director May 30,1930 St. Louis, MO Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: if item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at anne. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No Director Bethesda Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20817 10001 Carter Road U.S.A. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. ☐ Yes 2 🔯 No Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Patent Attorney 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lyda Cleone Shelton Louis F. Aitken 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2101 Cascade Rd., Silver Spring, MD 20902 Andrew C. Aitken/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State April 14, 4 ☐ Donation 5 ☐ Other (Specify) 2009 Potomac, Maryland St. Gabriel's 21. Signature of Fineral Service Lice 22. Name and Address of Facility DeVol Funeral Home 2222 Wisconsin Ave., N.W. Wash., D.C. 20007 Kun 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Prostate Cancer 10 Years disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or, injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and s the burial-transit Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy performed? 1□ Yes 2⊠ No death? 1 ☐ Yes 2□ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 No Certification; To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 1 M Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

To the Hospital or Attending Physlcian: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, 4 hours after death.

-uneral Director: A
ely filled in by the fu within 24 hours at To the Funeral C completely filled i

Baltimore, Maryland 21215-0036

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

(Check only one)

29c. License number

29d. Date signed (Month, Day, Year)

MD D0031586

April 7, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nancy A. Dawson, MD 3800 Reservior Rd., NW Washington, DC 20007

State Registrar

Medical

31. Date filed (Month, Day, Year) 09



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Phys.

1 - Registrar DOR, 4/21/09, LDB Certificate of Death

Reg. No. Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 29, 2009 4c. County of Death 2009 22:05 pM Hlbert 5Kins March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Cambri dae Vorcheste hester General If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) . Age (In yrs! last birthday) **Funeral** Months Days Hours 92.670 1 2 M 2 □ F Maryland Director Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 Ves 2 No bridge 10f. Zip Gode Director aM 10g. Citizen of What Country? 10e Street and Number Funeral 6 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🗷 No Black Specify Specify: <u>≥</u> 3 Widowed 4 Divorced "natural", Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within . Department of Health and Mental Hygiene. . Important: If item 27 Is marked other than ", any injury or other traumatic event, it a live, gonee. Elementary/Secondary (0-12) College (1-4or 5+) Sanitation-Supervisor Oultry Indu 18. Mother's Name (First, Middle, Maiden Surname). 17. Father's Name (First, Middle, Last) Be veille Cephas ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rd. Apt. 20 3 Cambridge, MD uc'ille altimore. 20b. Place of Disposition (Name of cemetery, crematory or other 20c. Location - City or Town State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State id Shore Cremation 16/09 ambridge, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. dge MD,21613 Cambri Approximate Interval Between Onset and Death 3 month S Immediate Cause (Final Cardiac biventricular **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ORTIC if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) requires that the death certificate be executed Cardio mo burial-tran and Due to (or as a consequence of): Box 68760. physician Physician/Medical the as attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No ed by the a P.0. 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 2 No 1 🗌 Yes 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate chanic 1 ☐ Yes 2 ☑ No Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA this Certification: To Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manper of Death 28c. Injury at Work? 28d. Describe how injury occurred After t 5 Pending investigation Hospital or Attending 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: 2 Accident the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Junacoli Sheekan DO H0068413

State Registrar

31. Date filed (Month, Day, Year) APR 03 200

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jennifer Fundion - Sneenan, Do 503A muir St. Cambridge MD Rebistrar's Signature

21613

		For State Registrar		State of M	larylan	•	artment of tificate of			ental Hy	giene Reg. No	2009	13032
Physic	an	1. Decedent's Name (First, Mi	, , ,						2	2. Date of De		v Xeak	3. Time of Death
/Medi		Carole Anne F								04	02		202
Exami	ner	4a. Facility Name (If not institu Holy Cross Ho			")		4b. City, Town, 6					. County of Dea Montgom	
Funeral		5. Social Security Number	6. Sex	x 7. A	ge (In yrs. I	ast birthday)	If Under 1 Year	If Under		B. Date of Bi (Month, D		_	thplace (State or Foreign
Director		579-46-2780	1 🗆]M 2 ⊠ F	74	Yrs.	Months Days	Hours	Min.	11/16/	1934		DC
and		Usual Residence of Decedent 10a. State 10b. Cou	ntv		10c. City	, Town or Lo	cation						10d. Inside City Limits
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Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any hipty or other traumatic event, the Medical Froming roust by neithed at gones.	Be Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 🔼 N 3 ☐ Widowed 4 ☐ Divord	arried	12. Was Deceden Armed Forces 1 □Yes 2 ☑ If Yes, Give Year or Dates	?		Vas Decedent of fYes, specify Cub i □Yes 2⊠No	oan, Mexica	ın, Puerto Ri	ify Yes or No ican, etc.)	0-	14. Race - Ame Black, White AT1 Specify: Ame	
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Vision of Vital Records, P.O. Box 6 Attending Physician: The law requires that the death certif cleath. sctor: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒No 9 ☐ Unknown	2	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fetal	death 3	Ectopic pregnan Other (specify) _	су				23d. Date of de Month	livery Day Year
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DHMH 17 Rev 1/2001

	•	For State Registrar	State of Mar	yland / Dep <i>Ce</i>	rtificate of			Reg. No.	nna	1303
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Physici		Robert Willia	am Burton				Month 04	06	Year 2009	9:00 A
/Medic Examin	- 20 La	4a. Facility Name (If not institution, g			4b. City, Town,	or Location of	Death	4c. Co	unty of Death	
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Funeral	1	5. Social Security Number 6	7. Age (In yrs. last birthday,	If Under 1 Yea Months Day		Min. (Month, D	ay, Year)	9. Birthp Cour	lace (State or Fore
Director		217-40-9351	IMM 2LIF	65 Yrs.	ĺ		05/04/	L943		MD
pu.		Usual Residence of Decedent 10a, State 10b, County	1	0c. City, Town or L	ocation				1	0d. Inside City Lim
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1 and 2 Health tem 27 I		Janice Hawkins/	riend	20b. Place of Disp		on Rd.,	<u>, Marydel,</u>		L649 ion - City or To	own State
8 4 = 0	1 3	20a. Method of Disposition 1226 Surial 2 ☐ Cremation		cemetery, cre	ematory or other p				-	
t. Pa tmen tant:		4 □ Donation 5 □ Other (Spe		Glen Hav)	4/07/09	,	Burnie	e, MD
permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Li	censee				elfenbein :			01.600
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	J.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pt 1 ☐ Live birth 2		□Ectopic pregna	ncv		230	. Date of deliv	*
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Graciela Angelica Carbajal Year April 5, 2009 8:41p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🕅 F NONE Director January 29, Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or items 23a or 28a-f shov the Medical Examinar, must be notified at MD Montgomery Silver Spring Director 1 ☐ Yes XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3503 Pear Tree Court Apt #21 20906 Peru Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 X Yes 2 ☐ No White þ Specify:Peruvian 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.

Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Primary School Principal 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be.
Department of Health and Mental important if flee 27 is more any injury or other. Tomas Carbajal Pilar Serrano 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mauricio Victor Guizado / Husband 3503 Pear Tree Court Apt. #21, Silver Spring, MD 20906 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 XX Cremation 3 ☐ Removal from State April 12, 2009 Alexandria, VA Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. West, Silver Spring, MD 20901 21. Signature of Funeral Service Licenses and 23a. Part 1. Enter the disease, or complications that arised the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, in heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Septic Shock Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Metastatic Cervical Cancer Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal dea 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 X No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2XXNo 1 ☐ Yes 2 X No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation Injury 1 ☐ Yes 2 ∏No after death Director: J 2 Accident 6 ☐ Could not be 3 Suicide

be executed anding physician and use as the burial-transi Box 68760. atter for u P.0. signed by the a of Vital Records, peen certificate this After thi funeral Division or Attending death.

within 72 hours after death

Mental

Maryland 21215-0036

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

DOOG7782 . APRIL 06 2009

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jawad Arshad 31. Date filed (Month, Day, Year)

4 Homicide

29a, Certifier

9901 Medical Center Drive, Rockville, MD 20850

State Registra

Medical

APR 09



within 24 hours aft.

To the Funeral Di

completely filled in Hospital

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Vear **Physician** 2:30 AM 2009 Huguette M. Clifford April /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince George Clinton Bradford Oaks If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 06/20/1919 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday **Funeral** 1 □ M 2 🕅 F 89 France Director 228-18-4165 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2XXNo Director Clinton Maryland Prince George with the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20735 U.S.A 7520 Surratts Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ∐Yes 2√TNo White þ Specify: 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed withi nent of Health and Mental Hygiene. 12 Accountant Accounting 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 27 is marked c Juilet Guilliam Hugh Clifford ပ permit. Pages 1 and 2 shoul Department of Health and M Important: If Item 27 is mark any Injury or other traumati once. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bruce Mottern (Brother) 5710 Spruce Dr. Clinton, MD 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/7/2009 4 ☐ Donation 5 ☐ Other (Specify) Clinton, MD Lee Crematory 22. Name and Address of Facility Lee Funeral Home, Inc. 21. Signatare of Funeral Service Licensee M01555 6633 Old Alexandria Ferry Rd. Clinton. MD 20735 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lin. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DII) us also **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Exami burial-trar Due to (or as a consequence of) P.O. Box 68760. attending physician for use as the buria The law requires that the death certificate be Physician/Medical IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☒ No 23d. Date of delivery 3 - Ectopic pregnancy Month Year Day 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 2 100 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s perform certificate 1 ☐ Yes 2 ☐ No 1 ☐Yes or Attending Physician; funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 200 Other: 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Vatural 2 Accident within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fur 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 29a. Certifier ying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. er: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the I 29b. Signature and title of certif

Registrar

State

3. Date filed (Month, Day, Year)

APK U 9 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 0230 M 0 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 3562 ASHLAND DRIVE ANNE ARUNDEL DAVIDSONVILLE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day,) 6. Sex 7. Age (In vrs. last birthday Funeral Year) WASHINGTON, D.C. Months Days Hours Min 12 M 2 F 579-64-6061 60 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner hast be notified at 1 ∏Yes 2X No Director MARYLAND ANNE ARUNDEL DAVIDSONVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3562 ASHLAND DRIVE items 23a 21035 UNITED STATES Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. within 72 hours after 0. 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: 2 Specify: WHITE 3 Widowed 4 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 UNION OFFICIAL LABOR traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be fi Department of Health and Mental. Important: If Item 27 is marked any Injury or or or PIETRO ANTHONY CATUCCI JUANITA GERTRUDE PELKA ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) TERESA L. CATUCCI/WIFE 3562 ASHLAND DRIVE, DAVIDSONVILLE, MARYLAND 21035 20b. Place of Disposition (Name of CHESAP CAKE CREMATION CENTER 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 3, 2009 4 ☐ Donation 5 ☐ Other (Specify) STEVENSVILLE, MARYLAND 22. Name and Address of Facility FELLOWS, HELFENBEIN AND NEWNAM CREMATION AND FUNERAL CARE, P.A., 814 BESTGATE ROAD, ANNAPOLIS, MARYLAND 21401 21. Signature of Funeral Service Licenses Well Export M00672 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MORINIC **Physician** 24 /Medical Due to (as a conseq ence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine be executed burial-trans Due to (or as a consequence of): Box 68760, attending physician Physician/Medical requires that the death certificate the use as t IE FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ρ in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) P.O. the 9 Unknown à s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Š 2 No 1 Tes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 After this certificate has autopsy perform 1 ☐ Yes 2 No 2 No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1□Yes 2☑No Other: 4 Nursing Home 5 Desidence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 1 ☑ Natural 2 ☑ Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Attending 5 Pending investigation 1 □Yes 2 🗆 No within 24 hours after death

To the Funeral Director: completely filled in by the f 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 6 To the Hospital within 24 hours a To the Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

19 Com

State Registrar Day, Yearl DD 0 32 Registrar's Signat

Name and address of person v

Degistrar's Signature

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completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Ciulla Theresa Ann April 2009 16:50 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's 14316 Pleasant View Drive Bowie If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Date of Birth (Month, Day, Year) 2/26/1950 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🔀 F Months Yrs 59 025-40-3362 Massachusetts Director Usual Residence of Decedent the Maryland 1∩a State 10b. County 10c. City Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examinations to notified at 1 XYes 2 No Funeral Director Bowie MD Prince George's 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 20720 14316 Pleasant View Drive USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2X No Specify. 2 If Yes, Give Year or Dates: Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 4 Registered Nurse Medicine 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Augustine Ciulla Theresa LaRosa ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Bowie, MD 20720 14316 Pleasant View Dr. Debra F. Murray/Sister 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Pages 1
Department of H
Important: If ite
any injury or of
once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/7/2009 Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Poneral Service Lie 22. Name and Address of Facility ensee Beall Funeral Home 6512 NW Crain Hwy. Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List entry one cause on each line. Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner 515 Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-tran Due to (or as a consequence of) Physician/Medical attending p IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No ☐ Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a d be detached for 9 Unknown 23e. Did tobacco use copyribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 1 ☐ Yes 3 Probably 4 Unknown been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b lirector, page 2 s autopsy performe 1 ☐Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only ene) Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this After thi 27. Manne of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No after death Director: / d in by the f 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide the Funeral Dire

Division of Vital Records, P.O. Box 68760,

State Registrar

completely

within 2

29a. Certifier (Check only one)

29b. Signature and title of certifie

29c. License number

1 V Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

D0101101340

St. Chevy chose, MD 20815

Name are address of person who completed cause of death (Item 23a) (Type, Print)

680

and manner stated.

XI Registrar's Signature

13038

		1- State Amend #8, 4-1	10-09, per	FHDR, Cer	uficate of l	Death		Reg. No.	7 13030
Physic	ian	1. Decedent's Name (First, Middle, Last	10	Cher	7		2. Date of Dea Month	Day _	3. Time of Death
/Medi Exami		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death	04	4c. County of	f Death
Funeral Director		5. Social Security Number 6. Se 579-68-8170	x 7. Age (II	In yrs. last birthday)	Buftr. If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 4/8/20		Gomery Birthplace (State or Fore Country) China
and and		Usual Residence of Decedent 10a. State 10b. County	10	Oc. City, Town or Loc	cation		1-26-1	928	10d. Inside City Lim
Maryl	tor	MD Howard		Ellicott (City				1 ☐ Yes 2 🔯
th the or 28s	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh	nat Country?
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filed within 72 hours atter death with the Maryland Hygiene. sither than "neturel", or iteme 23a or 28a-f show ent, the Medical Examiner must be notified at	d by Fu	1 ☐ Never Married 2 ☐ Married 3XX Widowed 4 ☐ Divorced	1 ☐ Yes 2X No If Yes, Give Year or Dates:		□Yes 2□KNo	Specify:	, , , , ,	Specify:	Asian White
"netu	Completed	15. Decedent's Edu (Specify only highest grad	cation le completed)	16a. Deced	ent's Usual Occupa kind of work done of	ation during most of work)	ing	16b. Kind of Bus	iness/Industry
d withi	dwo:	Elementary/Secondary (0-12)	College (1-4or 5+)	Homer		,		Own Hon	me .
be file tal Hyg d othe	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle,	Maiden Surname,)
hould d Men marke	7	Chen Shiu Ling 19a. Informant's Name/Relationship (T)	one Print)	19h Mailine	n Address (Street	Ip Ve]		r City or Town S	itate Zin Code)
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es 1 a of Hei of Hei of other		20a. Method of Disposition 1 Striat 2 □ Cremation 3 □ F		20b. Place of Dispos	sition (Name of natory or other plac		Date	20c. Location - C	ity or Town, State
t. Peg rtment rtent:		4 Donation 5 Other (Specify) 21. Signature of Funeral Service s	7 1	Linden Lir	othicum C	em. 4/10.	/2009	Clarksvi	
Depermination of the control of the		21. Signature of Funeral Services inceres	M0141	$\begin{vmatrix} 11 & \begin{vmatrix} 22 & 41 \end{vmatrix}$	Name and Address	olumbia I	ry H. Wi Pike, El	tzke's F	Family FH, Ir City, MD 2104
		23a. Part1. Enter the dise ye, or comp shock, or heart failure. List only o	lications that caused the ne cause on each line.	e death. Do not ente	er the mode of dyin	g, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death
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The law requires thet the death cert ate has been signed by the attending page 2 should be detached for use a	þ	Part II. Other significant conditions co	ntributing to death but n	not resulting in the un	derlying cause give	en in Part I.		_	oute to the cause of death? B Probably 4 DUnknow
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g Phy er this eral d	n: To	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of Injury (Month, Day Y	2 ER/Outpatient	28c. Injun	4 Serioursing Ho	-	lence 6 Other	
Attending Physician: or death. ector: After this certific. by the funeral director.	catlo	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be			M 1 🗆	Yes 2 □No			
al or At s after o bi Direct sd in by	Certification:	4 Homicide determined	28e. Place of Injury building, etc. (- At home, farm, stre (Specify)	eet, factory, office		28f. Location (S City or Tow		r or Rural Route Number,
To the Hospital or Attending Physician: The within 24 hours after death. To the Funarei Director: After this certificate his completely filled in by the funaral director, page	Medical (29a. Certifier 1 Certifying Phy 2 Medical Exami	sician: To the best of n ner: On the basis of ex and manner stated	camination and/or inv	occurred at the timestigation, in my of	ne, date and place, pinion, death occur	and due to the or red at the time, or	cause(s) and mand date and place, an	ner as stated. nd due to the cause(s)
To the within 2 To the complet	Me	29b. Signature and title of certifier	023		29c. License	s 5456		29d. Date signed	(Month, Day, Year)
102		30. Name and address of person who of	_			er late - 3l	1176	June Co	Vaint on 3
C	ate	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	ony ioi m	TIME #		ILVERS	Rim Moza

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** April 14, 2009 9:45 P Bernard Colbert Gordon /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Caroline Envoy of Denton Denton Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs, last birthday) Social Security Number **Funeral** Days Min. Months Hours 1 → M 2 □ F 96 Oct. 18, 1912 Virginia Director 579-10-0626 Usual Residence of Decedent 10c. City, Town or Location I0d. Inside City Limits 10a. State show 1 ☐ Yes 2 ☐ No r 28a-f sh notified Director Camp Springs Maryland Prince George's 10g. Citizen of What Country? 10e. Street and Number "natural", or items 23a or death with United States of America 20748 5901 Center Drive Completed by Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If frem 27 is marked other the any Injury or other transmitted. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 💆 No Specify ^{Specify:}Caucasian 3 ₩ Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Law Enforcement Police Detective 11 HS Grad 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Colbert (Unknown) William ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 24368 Asbury Drive, Denton, Maryland Craig M. Colbert Son Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/16/2009 Capitol Crematory Dover, Delaware 22. Name and Address of Facility Moore Funeral Home, P.A. 12 South Second Street, 21. Signature of Funeral Service License Denton, Maryland 21629 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PNEUMONIA Physician disease or condition resulting in death) Due to (or as a consequence of): /Medical **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) is certificate has been signed by the a director, page 2 should be detached in 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by CHRONIC OBSTRUCTIVE 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No DISEASE 24a. Was an perform this certificate 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Division or Vital Records, P.O. Box 68760, ours after death.

neral Director: A
filled in by the fu within 24 hours a To the Funeral I

The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and the of certific

30. Name and address of person v (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

BLOOMING BALK AVE,

State Registrar

			Please Type or Print in Black Indelible Ink. Ensure Al		-	
_			State of Maryland / Department of Health and M 1 - State Registrar Certificate of Death		g. No.	13040
	BI		1. Decedent's Name (First, Middle, Last)	2. Date of Death		3. Time of Death
J.	Physici: /Medic		Margaret F. Delano 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	April	Day Year 2000 4c. County of Dea	115 4
	Examin	er	4a. Facility Name (If not institution, give street and number) Dorchester General Hospital 4b. City, Town, or Location of Death Cambridge		Dorch	
	Funeral Director		5. Social Security Number 252-38-7763 6. Sex 1 Months 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) Months Days Hours Min.	8. Date of Birth (Month, Day, Feb. 13,	Year) Co	thplace (State or Foreign buntry) eorgia
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	a-f sh	ctor	MD Dorchester East New Market			1 □Yes 2 No
	th with the Maryland 23a or 28a-f show 18t bernullind at	Funeral Director	10e. Street and Number 10f. Zip Code 21631		g. Citizen of What Co Jnited S	•
))) 80	be filed within 72 hours after death with the Maryland trait Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Medical Examination and	by Funer	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 14. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No 16 Yes, Give 16 Yes, Give 17 □ Yes 2 ☑ No 16 Yes, Give 17 □ Yes 2 ☑ No 16 Yes, Give	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whit Specify: W	e, etc.
5_0	72 hou	eted	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work) life. DO NOT use retired)	ing 1	6b. Kind of Business	/Industry
7 21215_0036	be filed within 72 ho tral Hygiene. d other than "natur event, the Medical	Completed	Flementary/Secondary (0-12) College (1-4or 5+) Homemaker		Own Hom	e
Maryland	12 should be filed with and Mental Hygie 7 is marked other that traumatic event, In	To Be	17. Father's Name (First, Middle, Last) Edward Dominick 18. Mother's Name Ella		aiden Surname)	
No.	12 should the and Mer 7 is marke traumatic		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rur P.O. Box 996, Hurlock, MD 2		City or Town, State,	Zip Code)
	of Healt		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 2	Oc. Location - City or	
oltimoro.	t. Page rtment rtant: If		all Donation 5 □ Other (Specify) Bloomery Cemetery 04/1		Federals	
å	permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any injury or other trau		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fra 216 N. Main St., 1	mptom Fu Federalsl	neral Home ourg, MD 2	e, P.A. 1632
. 23	Dhysisian		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	or respiratory arre	st,	Approximate Interval Between Onset and Death
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09289 200	eath certificate be erattending physician for use as the burla	Medi	IF FEMALE: 23c. If yes, outcome of pregnancy			
	To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burlance.	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		23d. Date of de Month	Day Year
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4	g Phys er this	n: 70	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Metics	ome 5 ∐ Reside 28d. Describe ho	nce 6 ☐ Other (Sp w injury occurred	ecity)
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	s after (Certification:	4 Homicide determined building, etc. (Specify)	City or Town		
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	To the within To the compl	Me	29b. Signature and title of certifier 29c. License number		9d. Date signed (Mor	
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State Registrar

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			Decedent's Name (First, Middle, Last)					2. Date of De	ath CU	3. Time of D	eath
	Physicia /Medic		Norman Leslie Eckels	Jr.				Month March	31 200)9 10:30g	p M
SE JA	Examin		4a. Facility Name (If not institution, give street and number	er)		4b. City, Town,	or Location of I	Death	4c. County of	of Death	
		ü	1701 Brannocks Neck Ro			Cambi If Under 1 Year	-	Illm To D. (B)		chester	
	Funeral Director		219–36–6372 ★□M 2□F	Age (In yrs. I	Yrs.	Months Days		Min. 8. Date of Birl (Month, Da	y, Year)	9. Birthplace (State or a Country) Maryland	Foreign
	land w t		Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or Lo	cation				10d. Inside City	Limits
\overline{C}	e Mary ia-f sho tified a	Director	MD Dorchester			Cam	bridge			1 v Yes 2	2 □ No
7	with th a or 28	Dire	10e. Street and Number 316 Belvedere Avenue			10f. Zip Code	21613		10g. Citizen of W	-	
7	death ms 23	Funeral	11 Marital Status 12. Was Decede	ent Ever in U.	S. 13.1	Was Decedent of	Hispanic Origin	n? (Specify Yes or No	- 14. Race	- American Indian,	
336 6	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	Armed Force 1 Never Married 2 Married 1 Yes, Sive 3 Wildowed 4 Divorced Year or Date	ZNo		1 ☐ Yes 2 🔀 No		Puerto Rican, etc.)	Specify:	k, White, etc. White	
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nd 2	be filed tal Hygi d other event, ti	BeC	17. Father's Name (First, Middle, Last) Norman Leslie Eckels				1	s Name (First, Middle,		e)	
Maryland	should band Ment s marked umatic e	၉			10h Mailie	ag Addrona (Stron	L	le Elizabet or Rural Route Numb		State 7in Cade)	
Mai	id 2 sh Ith and Ith and 27 is n traun		19a. Informant's Name/Relationship (Type. Print) Margaret Eckels wif	- E		-		, Cambrido	-	21613	
	s 1 and if Health item 27 other to		20a. Method of Disposition	20b. P	Place of Dispo	sition (Name of matory or other pla	- 1	Date		City or Town, State	
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Balt	permit. Departr Importa any Inje		21. Signature of Funeral Service Licensee		1/4	2. Name and Addr	-	Thomas Fu Cambridge			
			23a. Part1. Enter the disease, or complications that cau shock, or heart failure. List only one cause on eac	sed the deatl h lin <i>e</i> .	h. Do not ent	er the mode of dy	ring, such as ca	ardiac or respiratory a	rrest,	Approximate Interval Between	een
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Ž	Physician: r this certific ral director,	o Be	examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inp	patient 2	ER/Outpatier	nt 3 DOA	ther	sing Home 5 Resi		er (Specify) daugh	
Division or Vital Records,	ding Physician: After this certific funeral director,	on: T	I A Hatulai 3 I ending	Injury Day Year)	28b. Time o Injury	W			how injury occurr	ed home	-
isio	I or Attending after death. Director: Afte I in by the fune	ficati	2 Accident investigation 3 Suicide 6 Could not be determined			M 1 [⊒Yes 2 □ N ===================================	28f. Location (er or Rural Route Numb	er,
Ω	tal or / s after al Dire ed in b	Certification:	4 ☐ Homicide determined building	, etc. (Specif	'y) 			City or To	wn, State)		
	To the Hospital or Attenwithin 24 hours after death To the Funeral Director:	ledical	29a. Certifier (Check only one) Certifying Physician: To the base and manne	is of examina							
	To the I within 2. To the I complet	Me	29b. Signature and title of certifier	\(\text{in} \)	1 /1	29c. Licer	nse number	- 27	29d. Date signed	(Month, Day, Year)	
•	7		77770	- N	1110.	PUC	0 (0	40	0416	111 2009	
	O	9	30. Name and address of person who completed cause RUIN W			Print) Eri	c Widma	der 21673			
	Sta Regist		31. Date filed (Month, Day Year) 32. APR 03 2009	gistrar's Signa	ature.	and					

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 4,2009 **Physician** Year 12:55am M Elsie E. Graham /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death 12113 Tawny Lane Bowie Prince George's 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min 1 ☐ M 2 💢 F 89 Yrs Director 160-26-0547 1-2-1920 PA Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. nnt: If item 27 is marked other than "natural," or Items 23a or 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f shov 1XYes 2□No Completed by Funeral Director Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20715 USA 12113 Tawny Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 📉 No Specify: White Specify: 3 XWidowed 4 □ Divorced treumatic event. If e Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Elder Care Registerd Nurse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Martha E. Squire 2 Oscar Culp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William A. Graham/Son 12113 Tawny Lane, Bowie MD. 20715 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ō <u>=</u> 1 Burial 2 Cremation 3 Removal from State Department of Importent: If any injury or once. 4-6-2009 Baltimore ,MD. 5 Other (Specify) * 4 Donation Bayview Crematory 21. Signature of Funeral S 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy. Bowie, MD 20715 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only no cause on each line. Immediate Cause (Final **Physician** amen disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 4 Pregnant at time of death 5 Other (specify) P.O. | the detached þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records. 1 Yes 2 No 3 Probably 4 Inknown Completed page 2 should 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No rmed? 2**/⊆**No 1 Yes funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) After t 28b. Time of 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 30. Name and address of person of death (Item 23a) (Type, Print) 38 De Pense Huy Gambrills mod 21054 31. Date filed (Month, Day, Year) State APR 08 Registrar

		Pleas	e Type or Print in				_	_	le.	
	_	For State Registrar	State of Maryla		ertificate of			Reg. No. 2	nq	13043
		Registrar Decedent's Name (First, Middle, in the content of the content	Last)				2. Date of De	ath	Van	3. Time of Death
Physicia /Medic		Howard	Neil Ha	milton			April	4, ^{Day} 2009	Year	23:42 M
Examin	_	4a. Facility Name (If not institution,	· .			Location of Death		4c. County o		orge's
Francis		Southern Marylar 5. Social Security Number 6		yrs. last birthda	Clin	If Under 24 Hrs.	8. Date of Bir	th	9. Birthpl	lace (State or Foreign
Funeral Director		232-48-4673	¹ X ^M ² □ F 74	Yrs.	Months Days	Hours Min.	March	29,1935	Coun	t Virginia
pu ×		Usual Residence of Decedent 10a. State		Od. Inside City Limits						
Maryla f sho	or	Maryland		Only Town of						1 □Yes 2 🗓 No
r 28a-	Director		George 5					10g. Citizen of W	hat Coun	try?
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tems	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	n U.S. 1	 Was Decedent of H If Yes, specify Cuba 	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No Rican, etc.)	- 14. Race Black	- America , White, e	an Indian, etc.
filed within 72 hours after death with the Maryland Hygiene. Hygiene, than "natural", or items 23a or 28a-f show ent, Ire Macinal Examiner must be notified at	by F	1 ☐ Never Married 2 ☐ Married 3 👿 Widowed 4 ☐ Divorced	1 ∏Yes 2 ∏No If Yes, Give X Year or Dates:		1 □Yes 2 No	Specify:		Specify:	Wh	ite
72 hounatura	ted	15. Decedent's (Specify only highest	Education	16a. De	cedent's Usual Occup	ation	kina	16b. Kind of Bus	siness/Inc	lustry
ithin 7 ne. han "r	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		ve kind of work done DO NOT use retired	d)	ung		0	
filed w Hygie ther ti	ပို	12 17. Father's Name (First, Middle, La	4 (st)	Sta	<u>itistician</u>	18. Mother's Nam	ne (First, Middle	Federal Maiden Surname		ernment
ild be fental rked c	To Be	Carl Hamilt	on			Eli	zabeth	Dent	on	
shou and N Is mai		19a. Informant's Name/Relationship			ailing Address (Street					
and and tealth m 27		Holly H. Hamilto			28 Skyrock		mbia, M	20c. Location - (
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Inc Marinal Examinations to other traumatic events to other events to other traumatic events to other events		20a. Method of Disposition 1 Disposition 2 □ Cremation 3	☐ Removal from State		position (Name of rematory or other place	Whiti	. 10,			
nit. Pa artme ortani injury		4 ☐ Donation 5 ☐ Other (Spe 21. Signature of Funeral Service Lie		Trinity	Memorial 22. Name and Addre		2009	Waldorf al Home,		
Dep Berr Buy Buy Onc		May Dist	all moors	-7		Гe				n, MD 20735
		23a. Part 1. Enter the disease, or co shock, or heart failure. List or	omplications that caused the colly one cause on each line.	leath. Do not						Approximate Interval Between
Physician		Immediate Cause (Final disease or condition resulting in death)	-a. Mussive	hemov	vhage L	ett thi	igh			3-26-09
/Medical Examiner		resulting in dealth)	Due to (or as a con	sequence of):	ysis - ind Knal Va	used las	Comme	edin llour	PIGOV	3-17-09
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a con	sequence of):	735 1000	1	CODDO	1	7	1.100
executed n and ial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	· mechanic	cal m	Mal Va	lue vep	lacen	ent		1488
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ne dea the att	Physician/Medica	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4 ☐ Pregnant at time 9 ☐ Unknown		5 ☐ Other (specify)			Mor	1(11	Day Year
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2 2 2	plete	History of Ceve	tuo Up decid	dut !	1994-19	196	24a. Was	an 24b. V	Vere auto	psy findings available mpletion of cause of
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y Physer this eral di	n: To	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of Injury (Month, Day, Yea		of 28c. Inju	ner: 4 □ Nursing H ry at		how injury occurre		y)
ending ath. pr: Aftu	atio	1 ► Natural 5 □ Pending 2 □ Accident investiga	tion	ar) Injur		k? Yes 2 □ No				
or Atte fter de girecto	Certification: To	3 Suicide 6 Could no 4 Homicide determin		At home, farm, pecify)	street, factory, office		28f. Location (City or To	Street and Numbe wn, State)	er or Rura	d Route Number,
To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page		29a. Certifier 1 2 CertifyIng	Physician: To the best of my	knowledge, d	eath occurred at the t	ime, date and place	e, and due to the	cause(s) and ma	nner as s	stated.
n 24 h	Medical	(Check only 2 Medical E	xaminer: On the basis of examiner stated.	mination and/o	r investigation, in my	opinion, death occu	irred at the time.	, date and place, a	and due to	the cause(s)
Vithi To the	ğ	29b. Signature and title of certifier	agas Dalo	iles	29c. Licens	e number		29d. Date signed	(Month	Day, Year)
		Main G. Cl	eccupace	//	D T		4:	apric		1 2001
3812		Main G-CHA	no completed cause of death MPALOUX W	(Item 23a) (Typ 10.	OP Print)	Man	16000	MI)	20772
Sta Registr	ite ar	29b. Signature and title of certifier 29b. Signature and title of certifier Main 6 - CHA 30 Name and address of person w Main 6 - CHA 31. Date filed (Month Day, Year)	33/ Registrar's S	Signature	arest					

	Plea	se Type or Print in B			•	_	э.
	1 - For State Registrar	State of Maryland		artment of Heal rtificate of Dea		ygiene Reg. No. 0 0	9 13044
Physician /Medical	1. Decedent's Name (First, Middle Juanita Rose				2. Date of I Month Apri	Day Ye	3. Time of Death 5:10 P M
Examiner	4a. Facility Name (If not institution College View	•		4b. City, Town, or Loca Frederic		4c. County of E	Death
Funeral Director	5. Social Security Number 359-09-4502	6. Sex 7. Age (In yrs. la 1	a <i>st birthd</i> ay) Yrs.	If Under 1 Year If U	nder 24 Hrs. 8. Date of E	Birth 9.	Birthplace (State or Foreig Country) Missouri
	Usual Residence of Decedent 10a. State 10b. County Marwal and Fraced	7,	, Town or Lo		į į į į į	, 1010	10d. Inside City Limits 1⊠Yes 2 □ No
fler death with the Marritems 23a or 28a-fs	Maryland Fred 10e. Street and Number 1421 Taney Av		deric	10f. Zip Code 21702		10g. Citizen of What	t Country?
o, la	3⊠ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 □ Yes 2 ☒ No	1	_	c Origin? (Specify Yes or I xican, Puerto Rican, etc.) ecify:	14. Race - A Black, W Specify: W	American Indian, /hite, etc. /hite
ygiene. yer than "naturat, the weden!	15. Deceder (Specify only highe Elementary/Secondary (0-12)	nt's Education st grade completed) College (1-4or 5+)	(Give life. l	dent's Usual Occupation kind of work done during DO NOT use retired) ness Owne:		16b. Kind of Busine	oss/Industry Dry Cleaning
Mental Hygi Mental Hygi arked other atic event, I	17. Father's Name (First, Middle,			18. N	Mother's Name (First, Midda ace Mabel	le, Maiden Surname)	ory oreasing
t and 2 sho Health and Hear traums	19a. Informant's Name/Relations Mark Herr /	Son	100	Chapel Ct	· · · · · · · · · · · · · · · · · · ·	lkersvill	e, MD 21793
nit. Pages artment of lortant: If ite	20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (S	pecify) Rest	thaven	sition (Name of natory or other place) Crematory Name and Address of F	April 9,		ck, Maryland
Depa Impo any any	23a. Pml 1. Enter the disease, or shock, or he mailure. List	complicant his that caused the death.		sthaven Fu 01 Catocti	ineral Serv n Mtn. Hwy.		ot Cody P.A k, MD 21701 Approximate Interval Between Onset and Death
Physician /Medical Examiner	Immediate Cau (Final disease or condition resulting in 1 ath)	Due to (or as a conseque	ence of):	ILL CARC	rond, me	ASTATIC	ZYRS
executed in and ial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a conseque					
ficate be executed physician and street the burial-transit edical Examir		d.	ence oi).				
ng Physician: The law requires that the death certificate be ifter this certificate has been signed by the attending physicial inertal director, page 2 should be detached for use as the bur To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ Mo 9 □ Unknown	23c. If yes, outcome of pregnan 1 ☐ Live birth 2 ☐ Fetal (4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3	Ectopic pregnancy Other (specify)	_	23d. Date of Month	delivery Day Year
e law requires that the de has been signed by the le 2 should be detached mpleted by Physic	Tart ii. Other significant condition	ons contributing to death but not result	lting in the ur	nderlying cause given in F			e to the cause of death? Probably 4 10nknown
sician: The law requir certificate has been s rector, page 2 should					24a. Wa aut per 1 ∐Yes	opsy prior formed? deatl	e autopsy findings available to completion of cause of n? Yes 2 Mo
siclan certifi rector	25. Was case referred to medical examiner?	Hospital:		0.1	Place of Death (Check only		
Ing Physician: After this certifice uneral director, p	1 ☐ Yes 2 ☐ No 27. Manner of Death 1 ☐ Natural 5 ☐ Pendin	28a. Date of Injury	ER/Outpatien 28b. Time of Injury	1 3 LI DOA 4 E	Nursing Home 5 Re	sidence 6 Other (Se how injury occurred	Specify)

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral

Medical Certification

2 Accident

3 Suicide

29a. Certifier (Check only one)

4 ☐ Homicide

29b. Signature and title of certifier

5 Pending investigation

6 Could not be determined

APR 0 9 2009

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANDREW 65C THOMAS UD HISON DR. DONELSON, MD 31. Date filed (Month, Day, Year)

32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

М

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

121936

28f. Location (Street and Number or Rural Route Number, City or Town, State)

FREDERICK,

29d. Date signed (Month, Day, Year)

83

#18186, AU4176435518186

, 22 S. GREENEST. BALTIMURE MD

04-09-2009

J. SCALEA, MD

SCALEA

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOSE PH

31. Date filed (Mo

State Registrar

		-	For State Registrar	State of Ma	ryland /	•	rtment of F tificate of t			glene leg. No 20 (9	13046
Phy	/sicia		1. Decedent's Name (First, Middle, Las	•					2. Date of Deat Month	Day	Year	3. Time of Death
	ledic	al		Ingberg	_				Hpril	4c. County o	2009	1445 M
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Fun	eral		5. Social Security Number 6. Se	7. Age	(In yrs. last b	irthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day Apr • 2		9. Birthpla	ace (State or Foreign
Direc			579-40-9409	□ M 2 🛣 F	76	Yrs.	Months Days	Hours Min.	Apr. 2	,1933	Mary	Mand
and		-	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tov	wn or Lo	cation				10	d. Inside City Limits
Aaryli C	led at	ō	Maryland Wicomio	70	Salis							1 □ Yes 2 No
7 ag 188	natit	- A -	10e. Street and Number		Daire		10f. Zip Code		1	l0g. Citizen of W	hat Count	ry?
23a o 23a o	of la	a D	400 Woodcrest	Avenue			21	801		Ţ	JSA	
Baltimore, Maryland 21215-0036 (Examinerms	₽	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Wildowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1	Ever in U.S. Io		Was Decedent of H fYes, specify Cuba I □Yes 2X No	lispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- pecify Yes or No- pecify Yes	14. Race Black Specify:	- America , White, et W	an Indian, tc. hite
5-0 72 hc	dical	etec	15. Decedent's Ed (Specify only highest grades)	ucation de completed)	16	a. Dece	dent's Usual Occup kind of work done	eation during most of world)	king	16b. Kind of Bus	iness/Indu	ustry
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d 2 filed v Hygie	aut, #	ပိ	17. Father's Name (First, Middle, Last)					18. Mother's Nam	ne (First, Middle, i	Maiden Surname		
land be	tic ev	To Be	William Rabbit	t				Mary	Padget	t		
ary shou and N	numat		19a. Informant's Name/Refationship (7	ype. Print)				and Number or Ru				
and 2 and 2 n 27 i	er tra		Douglas N. Mart	in/Son				Court,				
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours aft Department of Health and Mental hygiene. Important: If Item 27 is marked other than "natural", or Important:	ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			tor		mar.4/6/	2009	20c. Location - 0 Delmar,	, De	laware
Balt permit. Depart Import	any in	1	21. Signative Funeral Service Life	Sall	lew	Z	Name and Addre	ss of Facility Uneral 1 Ocean (Home,P.	O. Box .,Sali	317 sbur	1 Y,MD
Di		-4	23a, Part 1. Enter the disease, or com- shock, or heart failure. List only Immediate Cause (Final			o not ent	er the mode of dyir	ng, such as cardiac	or respiratory arr			Approximate Interval Between Onset and Death
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68760, ificate be executed g physician and	buria	a E			a consequence	0 01).						
		edical		d								
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cords, P.O. w requires that the di	g	ρ	Part II. Other significant conditions of	ontributing to death bu	ut not resulting	in the u	nderlying cause giv	ren in Part I.				e cause of death? ably 4 // known
aw rec	shor	Completed							24a. Was a			osy findings available
Refament	age (mo							autops perfor 1 □ Yes	med? d	rior to com eath? □Yes :	npletion of cause of
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of V physic	al dire	၉	1 Yes 2 No		nt 2 ER/0			4 🗆 Nursing H	ome 5 Resid)
Division of Vital Re or Attending Physician: The strength death. Director: After this certificate ha	funers	ion:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injui (Month, Day		. Time o Injury	Wor	k?	28d. Describe h	ow injury occurre	d	
isic ittend death death	the f	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		iry - At home	farm str	eet, factory, office	Yes 2□No	28f Location /S	treet and Numbe	r or Rumi	Route Number
Division of Vital Record tal or Attending Physician: The law requir rs after death.	led in by	Certification:	4 Homicide determined	building, etc	. (Specify)				City or Tow		7 07 710707	Trodio Prantosi,
To the Hospital within 24 hours a To the Funeral	completely filled in by the	Medical		ysician: To the best on the basis of and manner sta	f examination a							
To the within 2	CONT	Σ	29b. Signature and title of certifier				29c. Licens			April 6		
Q	2		30. Name and address of person who of RENE L. DESMAI		eath (Item 23a	(Type,	Print)	st Salice	bune 1	nd 218	801	
	Sta		31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	4	1 1		7			
Re	gistr	ar	APR 07	2005 Bear	was p	9. 1	BENEV					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** 04 2009 05 7:20AM Betty Jean Jones /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🔯 F 53 577-76-2932 1/16/1956 DC Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shot traumatic event, "he Modical Event, "he modical Event". Director DC 1 Tr Yes 2 □ No Washington 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? 2 should be filed within 72 hours after death with to and Mental Hygiene.
Is marked other than "natural", or items 23a or 2 7220 14th Street, NW 20012 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ※ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status African 1 ☐Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: 3 Widowed 4 Divorced American Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) Public Health 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Service Specialist DC Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Parker Dunford Jones, Sr. Betty Lou Humphrey ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau Jocasta Jones/Daughter 3531 Manorwood Drive, Hyattsville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Rock Creek Cemetery 4/13/2009 4 ☐ Donation 5 ☐ Other (Specify) Washington, DC 22. Name and Address of Facility McGuire Funeral Service, Inc. cholo 7400 Georgia Avenue, NW Washington, DC Shoe 20012 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Metastatic Breast Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE yes, outcome of pregnancy

□ Live birth 2 □ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 ☐ Other (specify) ed by the detached signed by the detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ≥ icate has been siç ; page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an autopsy certificate 2 **X** No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2⊠ No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 27. Manner of Death Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28c. Injury at Work? 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 🛛 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 1) 052586 09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Jayanti Patel, 1500 Forest Glen Road, Silver Spring, MD 20910 31. Date filed (Month, Day, Year) 2. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** Etta M. Jones 2009 April 1:00 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Genesis Eldercare Severna Park Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 411-30-3136 1 □ M 20XF 84 Tennessee **Director** 4, 1924 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examiner must be notified at Maryland Anne Arundel Annapolis ¥XYes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21403 830 Bay Ridge Avenue U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ∐Yes 2XXXNo Specify Specify: White Completed by 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other the any injury or other traumatic event. Accountant Internal REvenue Ser. 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wilbur Robinson Eva Moore ဂ 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 830 Bay Ridge Avenue Annapolis, Maryland 21403 Linda Drager/daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 XX remation 3 ☐ Removal from State Baltimore Crematory 4/9/2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** days Vas disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Due to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mg Month Day Year Pregnant at time of death 5 ☐ Other (specify) ∐Yes 2 **W**No P.0. been signed by the should be detached 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>\$</u> 2 No 3 Probably 4 Inknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an cate has t page 2 s autopsy certificate 1 □Yes 2 1 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manne of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 ☐ Pending investigation death. 1 ☐Yes 2 Accident reral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide 24 hours a 29a. Certifier 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical pletely (Check only and manner stated. the 29b. Signature and title of certifier ٥ 30. Name and address of person who completed cause of death (Item 23a) (Type ans Hwy

State Registrar 31. Date filed (Month, Day,

APR 08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 12, 2009 Ann Elizabeth Jackson April 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Casey House Rockville Montgomery 8. Date of Birth (Month, Day, Year)
July 16, 1942 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 1 □ M 2 🗓 F Months Days Hours Min. 66 Yrs. 228-54-3041 Virginia Usual Residence of Decedent 10a, State 10b County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🛛 No MD Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18018 Cottage Garden Dr. Apt#101 20874 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify Specify: Black 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) retail credit Elementary/Secondary (0-12) College (1-4or 5+) clerk/secretary department 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Andrew Jackson Pearl Ball 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JoAnna Gomes-Haddocks 704 Twinbrook Pkwy, Rockville, MD 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Date cemetery, crematory or other pla Enders & Shirley Funeral Home 1 ☐ Burial 2 🌠 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04/14/09 Berryville, Virginia 22. Name and Address of Facility Hilton Funeral Home P O Box 86, Barnesville, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final End Stage Chronic Obstructive Pulmonary Disease disease or condition resulting in death) Due to (or as a consequence of): Due to (or se a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Year Dav 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No performed 1 ☐Yes 2 ☐No 26. Place of Death (Check only one)

/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Division of Vital Records, P.O. Box 68760 been signed by the should be detached s certificate has b irector, page 2 sl director, funeral After after death Director: / d in by the f

Physician

/Medical

Examiner

Funeral

Director

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Health and Mental Hygiene.

Department of Health Important: If item 27 any injury or other trong once.

Physician

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Expiration class be notified at

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Funeral

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Completed

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Pages 1 and 2 should be filed within 72 hours after death with the Marylan

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner resulting in death) Last Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🖾 No δ Ca unk primary/ liver metastasis Be Completed Hypertension G I Bleed 25. Was case referred to medical examiner? 1 Yes 2 XNo Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 1 X Natural 2 ☐ Accident 5 Pending investigation 6 Could not be determined 3 Suicide 4 Homicide

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospice IPU 28d. Describe how injury occurred 28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

APRIL 12, 2009

29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Kouch

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHOU, 20855 JOCELYNE KOUEIK MD 6001 MUNCASTER RD., ROCKVILLE, MD

State Registrar

filled in 24 hours a

within 24 hor To the Fune completely fi

Medical

31. Date filed (Month. Day, Year) 32. Registrar's Signature

Jocelyne

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav **Physician** Gloria Eve Klombers 31. 2009 20:27 March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5411 McGrath B1vd #322 Rockville Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗓 F 79 Yrs. Director 06/29/1929 New York 094-22-6893 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show 1 and 2 should be filed within 72 hours after death with the Maryla Heatth and Mental Hygiene. It is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Martical Examinar must be notified at 1 X Yes 2 □ No Director MD Montgomery Rockville 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 5411 McGrath Blvd #322 20852 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 ☐ Yes 2 ☐ X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Legal Assistant Corporate Council 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Israel Piatek Rose Krapes ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Heatth ar
Important: if item 27 is
any injury or other trau 5411 McGrath Blvd #322, Rockville MD 20852 Norman Klombers husband 20b. Place of Disposition (Name of cemetery, crematory or other place)
Garden of Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04/12/09 Clarksburg, MD Remembrance 22. Name and Address of Facility Danzansky-Goldberg Memorial Chapels Inc 21. Signature of pheral Service Licensee 1170 Rockville Pike, Rockville, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 24 Hours Immediate Cause (Final Congestive Heart Failure Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Arteriosclerotic Cardiovascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Box 68760, ned by the attending physician detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Day Year 4 Pregnant at time of death 9 Unknown 5 Other (specify) P.O. 9 Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 2 No 3 Probably 4 Unknown 1 🗌 Yes cate has been si page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate 1 ☐ Yes Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examiner? 1∭Yes 2□No Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No Hospital or Attend 24 hours after death Funeral Director: 2 Accident completely filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 24 hours a 1 X certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the companies. 29a. Certifier Medical basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check onl ated. To the within 2 To the F 29c. License number 29d. Date signed (Month, Day, Year) 29b. Sign April 1, 2009 D21531 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Gabriel Pushkas,

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31. Date filed (Month, Day, Year)

MD

DHMH 17 Rev 1/2001

11510 Old Georgetwon Road

32. Registrar's Signatu

Rockville, MD 20852

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Amend# 17Per: FH 1 - State A/20/09 AACO HEALTH DEPT. CMH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month 04 **Physician** 13:30 M Anton wamer 00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University of Maryland Medical Bultimore Baltmore City Lenter If Under 1 Year | If Under 24 Hrs. | Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Hours Months Davs Director December 1944 212-42-0098 64 Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or items 23a or 28a-f sho 1 ☐ Yes 217 No Director MD <u> Anne Arundel</u> <u>Annapolis</u> 10e. Street and Number 10g Citizen of What Country? 21401 1905 Luce Creek Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene.
unt: If item 27 is marked other than "natural", or ite 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo Specify: White \$ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry National Elementary/Secondary (0-12) College (1-4or 5+) Capital Industries 7 is marked other traumatic event, I Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Andrew A. Kramer III Jr Nancy Clarke ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and : Department of Health Important: If item 27 any Injury or other tr. once. Edgewood Court, Annapolis, MD 21403 Jocelyn Malone - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Crematory 4/8/2009 Baltimore, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility John M. Taylor Funeral Home, Inc Muzelini 147 Duke of Gloucester St, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a con uence of): Examiner tra-abdomina Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the Hospital or Attending Physician: The law requires that the death certificate be executed rdio genic burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 XYes 2 No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 No autopsy performed? funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 5 \sum Residence 6 \subseteq Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation nours after death.

neral Director: Af 1 □Yes 2 □ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a

To the Funeral C 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 04.06,2009 PZ1184 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Emily Corrigan M.D WMMC ZZS Greene St Box Z90 Bultimore, MD 21201 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature State

Registrar
DHMH 17 Rev 1/2001

			For State Registrar	State of Marylan		rtificate of t			gierie Reg. No.2	13052
	Physicia	an	1. Decedent's Name (First, Middle, La	·				2. Date of Dea Month	Day Year	3. Time of Death
m.	/Medic		Patric		hart			April	7, 2009 4c. County of Dea	10:11 A ^M
	Examin	er	4a. Facility Name (If not institution, gir Holy Cross I				r Location of Death er Spring	1	Montgo	
	Funeral		5. Social Security Number 6.	Sex 7. Age (In yrs.	last birthday)	If Under 1 Year Months Days		8. Date of Birtl (Month, Day 1 – 30 –	_	thplace (State or Foreign ountry)
	Director		5/1-92-0209	¹	Yrs.	World bays	Tiodis Willi.	1-30-	58 N	. J´.
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	ty, Town or Lo	cation				10d. Inside City Limits
	Mary a-f sh	tor	MD. P.	G. F	ort Wa	ashingto	on			¥ Yes 2 No
	ith the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	
	s 23a	eral	8303 Fort Fo		5 110 1	2074		situ Voo or No	U.S.A 14. Race - Am	
21215-0036	be filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or items 23a or 28a-f show event, the "natural Event, the standard Event	d by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		was Decedent of H If Yes, specify Cuba 1 ☐ Yes XXNo	lispanic Origin? (Spec an, Mexican, Puerto R Specify:	lican, etc.)	Specify: B	te, etc. lack
15-("natu	lete	15. Decedent's E (Specify only highest gr	ducation ade completed)	1 (Give	dent's Usual Occup kind of work done of DO NOT use retired	durina most of working	g	16b. Kind of Business	/Industry
212	within jene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 4			"Care Ma	nager	Private	
þ	e filed val Hygie other i	Be C	17. Father's Name (First, Middle, Las)			18. Mother's Name		•	
ylaı	should be fand Mental s marked o umatic eve	2	Harold Lo				Milfo			
Maryland	and 2 sh salth and 1 27 is m er traum		19a. Informant's Name/Relationship Milford Lockh			,			er, City or Town, State, Vash. Md.	
	s 1 an if Heal item 2 other		20a. Method of Disposition			sition (Name of natory or other place		ite	20c. Location - City of	
Baltimore,	permit. Pages 1 and 2 should I Department of Health and Men Important: If Item 27 is marke any injury or other traumatic once.		1 Surial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control Co	ry) Fo	rt Li	ncoln C	em. 4/18		Brentwoo	•
Bal	permit. Departimont. Import. any inj.		21. Signature of Funeral Service Lice	Hackest An.		814- U	<u>pshur St</u>	reet,	napel, In N.W. DC	c. 20011
ı			23a. Part 1. Enter the disease, or con shock, or heart failure. List only	plications that caused the deat one cause on each line.	h. Do not ent	er the mode of dyir	ng, such as cardiac or	respiratory ar	rest,	Approximate Interval Between Onset and Death
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7	Examiner			Due to (or as a conseq	uence of):					Days
	n +	ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conseq	uence of):					_
9	ecuter and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C						
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68760,	ificate g phys as the	edical		_d						
.O. Box	the death certific by the attending p	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 MNo 9 □ Unknown	23c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of 6	al death 3 [Ctopic pregnanc Other (specify)	by		23d. Date of d Month	elivery Day Year
S, P.	The law requires that the date has been signed by the bage 2 should be detached	by Pt	Part II. Other significant conditions	•	ulting in the u	nderlying cause giv	ren in Part 1.		obacco use contribute	
ord	equire een si iould b		Morbid Obes	ity				1 🗆 \	/es 2 No 3 F	Probably 4 X Unknown
3ec	2 2 2	Completed	<u>Diabetes Me</u>	llitus				24a. Was autop	an 24b. Were a prior to death?	autopsy findings available completion of cause of
a			Hypertensio	n			00 Di	1 ☐ Yes	2X No 1 □ Ye	s 2 No
Ē	ysicia s certi directo	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☑ Inpatient 2 □	ER/Outpatie	nt 3 DOA Oth	26. Place of Death ner: 4 □ Nursing Hom		<i>ne)</i> dence 6 □Other <i>(Sp</i>	ecify)
n of	ng Ph fter thi	on:To	27. Manner of Death 1 ★ Natural 5 Pending	28a. Date of Injury (Month, Day, Year)	28b. Time o				now injury occurred	
Division of Vital Records,	Attending Physician: r death. ector: After this certific by the funeral director, I	catic	2 Accident investigation 3 Suicide 6 Could not be			M 1 🗆	lYes 2□No	Of Leasting (24	Donal Books Morelson
Ξ	5 € € □	Certification:	4 ☐ Homicide determined		ome, farm, str fy)	еет, тастогу, опісе	2	City or Tov	Street and Number or I vn, State)	turai Houle Number,
_	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier 1 Certifying P	hysician: To the best of my kno miner: On the basis of examina	owledge, deat	h occurred at the ti	ime, date and place, a	and due to the	cause(s) and manner	as stated.
	the H hin 24 the F mplete	Medical	one)	and manner stated.	allott and of the	29c. Licens			29d. Date signed (Moi	
		~	29b. Signature and title of certifier	W		D32			04/07/09	
	3		30. Name and address of person who	completed cause of death (Iter	m 23a) (Tvpe.	Print)				
_			Suresh K. Gu	pta, M.D. 98	01 Ga	. Ave.,	S.S,	Md. 20	0902	
	Sta Registr		31. Date filed (Month, Day, Year) APR 0 9 20	32. Registrar's Signa	ature far	KI				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2009 2:501 **Physician** DRI David Bruce Lutz /Medical County of Death 4a. Facility Name (If not institution, give street and number) Town, or Location of Death Examiner Plata MEDICAL ENTER a 10 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months | Days | Hours | Min. | November 26, 9. Birthplace (State or Foreign 195 fountry) 5. Social Security Number 7. Age (In yrs. last birthday) 1 X M 2 □ F 57 165-44-1341 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d, Inside City Limits 10a. State 1 □Yes 2 No Director Maryland Charles 10e. Street and Number Waldorf 10g. Citizen of What Country? 10f Zip Code USA 20602 Funeral 3407 D. White Fur Court 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc 1 Mayes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Analvst 12 Masters 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Alberta Hoffman ൧ Gordon D. Lutz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) White Fur Court, Waldorf, MD., 20602 3407 D. Sharon Dombrowski/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State April 8, 2009 Waldorf, MD. Huntt Crematory 5 Other (Specify) 4 Donation 21. Signature of Funeral Servis 22. Name and Address of Facility Huntt Funeral Home 3035 Old Washington Rd. Waldorf, MD. 20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 ☐ Other (specify) 9 Unknown 23e. Did topacco use contribute to the cause of death? þ 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □ No 24a Was an autopsy 2 DNo 1 □ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Certification: To

requires that the death certificate be executed physician and s the burial-trant Box 68760. attending pleas to signed by the a P.0. Division of Vital Records. been signal page 2 s certificate

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 shov any injury or other traumatic event, the Medical Experiment out to rectifie at

Physician

/Medical Examiner

altimore, Maryland 21215-0036

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

examiner? 1 ☐ Yes 2 🗖 🗸	0	Hospital:	1 Inpatient	2 🗆	ER/Outpatient 3	3 🔲 [OOA Other: 4 I Nursing H	ome 5 ☐ Re	sidence 6 ☐ Oth	er (Specify))
27. Man rer of Death 1 atural 2 Accident	5 Pending investigation		Date of Injury (Month, Day, Y	ear)	28b. Time of Injury	М	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe	e how injury occurr	ed	
3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e.	Place of Injury building, etc. (- At h	ome, farm, street, fy)	facto	ory, office	28f. Location City or To	(Street and Numb own, State)	er or Rural	Route Num
29a. Certifier 1 (Check only 2 one) 2		iner: Or		amin			ed at the time, date and place on, in my opinion, death occu				
29b. Signature and til	tle of certifier	00	r /	7		2	9c. License number	,	29d. Date signed	d (Mønth, þ.	ay, Year)

7C POST OFFICE Rd Weldorf ND 20602

BBID

State Registrar

Medical

non

Cenna Medical 32. Registrar's Signature

30. Name and address of erson who completed cause of death (Item 23a) (Type, Print)

MA

			For State Registrar	State o	f Marylar	-	artment o rtificate			Mental H	ygiene Reg. No.	2009	13054
	636	-	Decedent's Name (First, Middle, La.	st)						2. Date of	Death		3. Time of Death
	Physici		Lena Pearl	Lilly						Month 04	Day 13	2009	7:00A ^M
· F	/Medic		4a. Facility Name (If not institution, giv		nber)		4b. City, To	wn, or Loc	cation of Dea	ath		County of Deat	
8	201	- 10 mg	Hospice of Queen	n Anne's	5		Cer	ntrev	ville			Queen	Anne
	Funeral		5. Social Security Number 6. S	_	7. Age (In yrs.	. last birthday)	If Under 1 \		Under 24 Hr	s. 8. Date of (Month.	Birth Dav. Year)	9. Birt	hplace (State or Foreign untry)
	Director		234-22-0262	□M 2[3kF	92	Yrs.	Months	, ayo	10010	Feb 26	Day, Year) 1917		. Virginia
	pu »		Usual Residence of Decedent 10a. State 10b. County		10c Ci	ity, Town or Lo	cation						10d. Inside City Limits
	short short	'n	Maryland Talbot			aston	odiioi /						1 ZYes 2 □ No
	the N	Director	10e. Street and Number			aston	10f. Zip Co	do			10g Citis	zen of What Co	unte /2
	a or		610 Dutchmans La	3.0				1601					unity:
	eath	eral	11. Marital Status	,	edent Ever in U	IS 13 1			anic Origin?	Specify Yes or		J.S.A. 14. Race - Ame	rican Indian.
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at ance.	by Funeral	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	Armed Fo 1 Yes If Yes, Giv Year or D	rces? 2 🔼 No /e		f Yes, specify		Mexican, Pue Specify:	Specify Yes or erto Rican, etc.)		Black, White	
ğ	2 hot	Completed	15. Decedent's Ed				lent's Usual C				16b. Kii	nd of Business/	Industry
215	hin 7. 9. An "n Medi	ple	(Specify only highest gra	Gollege (1	-4or 5+)	(Give life. i	kind of work o	done durii retired)	ng most of w	orking	Ŧ		
2	d wit	ρ	Elementary/Secondary (0-12)			1	nomemal	ker				own home	2
	e file al Hy I othe vent	Be	17. Father's Name (First, Middle, Last)				18	. Mother's N	ame (First, Mido	lle, Maiden	Surname)	
<u>a</u>	Ment Ment arked	2	William C. Sensal	oaugh				V	Virgie	Collin:	s Sens	sabaugh	
Maryland	2 sho and is me	Ū	19a. Informant's Name/Relationship (•			Pural Route Nui			•
	and sealth n 27		Betty Williams/ n	niece					Drive	; Berli	_		
ore	of H		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □	Removal from	- 1	Place of Dispo cemetery, crei	sition (Name natory or othe	of er place)		Date	20c. Lo	cation - City or	Town, State
altimore,	Pag ment ant: ury c		4 □ Donation 5 □ Other (Specif			k Grove			-	18/09	Beck	cley, We	est VA
Ball	permit Depart Import any in	ea l	21. Signature of Funeral Service Licer	Fle	11	F:		and 160;	Helfe Green	nbein F sboro, l		Home,	PA
п			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that o	aused the dea ch line.	th. Do not ent	er the mode o	1	, ,	ac or respirator	arrest,		Approximate Interval Between
5	Physician		Immediate Cause (Final disease or condition	. L	onges	tive	Kears	ta	Mure				Months
E.	/Medical Examiner		resulting in death)	Due to	or as conse	quence of):	1.	/	H				
	Examiner	L	Sequentially list conditions,	6	chemi	ic car	riomy	opper	eny				years
100	e sit	ine	Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to	or as a conse	quence of):							
	cate be executed ohysician and the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to	or as a conse	nuance of):							years
8760,	be ex cian burial	E		Due 19	A 11	Serosis							
87		dical		d	JRIN SI	10/07/3							years
×	certifi ding se as	/Me	IF FEMALE:	23c. If yes, out	come of orear	nancy						,	·
Вох	that the death certifii ed by the attending I detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live b	oirth 2 ☐ Fet nant at time of	tal death 3□	Ectopic preg				2	23d. Date of del Month	Day Year
Ö	the d / the ched	ysi	1 □ Yes 2 X No 9 □ Unknown	9□Unkn		dodin o'E	300101 (0)000	.,,			-		
Records, P.O	The law requires that the death certificate has been signed by the attending tage 2 should be detached for use as	/ Ph	Part II. Other significant conditions	contributing to de	eath but not re	sulting in the u	nderlying caus	se given i	n Part I.	23e. D	d tobacco u	se contribute to	the cause of death?
g	puires n signe lld be	d by								1	Yes 2	□No 3 Pr	obably 4 □Unknown
Ö	w require been sign	Completed								24a. W	as an	24b. Were au	itopsy findings available
Be	he la e has ige 2	E C								- au	topsy rformed?	prior to death?	completion of cause of
Vita	in: T ificate or, pa		25. Was case referred to medical					26	R Place of D	1 Ye		1 ☐ Yes	2 □ No
>	s cert	o Be	examiner? 1 ☐ Yes 2 No	Hospital:	Inpatient 2	BR/Outpatier	t 3□ DOA	Other:		eath (Check on Home 5□R		S DOthor (Sac	oih)
Ö	Attending Physician: r death. ector: After this certifica by the funeral director, i		27. Manger of Death	28a. Date	of Injury	28b. Time o		. Injury at Work?	* -	28d. Describ			Cny)
on	ndlng th. :: Afte	tio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	,	th, Day Year)	Injury	M		s 2 □ No				
Division or	Attenc r death ector: by the	tics	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place	of injury - At h	nome, farm, str	eet, factory, c	ffice		28f. Location	(Street an	d Number or Ru	ural Route Number,
Ö	al or A s after al Dire	Certification:	4 Homicide	Dulla	ng, etc. (Spec	ary)				City or	Fown, State)	
	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical (29a. Certifier Check only one) Certifying Pt 2 Medical Example 1	miner: On the b									
	omple	Me	29b. Signature and title of certifier	anix	110		29c. L	icense nu	umber	MI	29d. Dat	e signed (Mont	h, Day, Year)
	->F0)	Hell	WIN	3			1119	199		4113	.09
7			30. Name and address of person who	completed caus	of death (Ite	m 23a) (Type.	Print) ,		,		1	, , ,	221
			MTD Crowley,	MD	, 610) Tu	Khimo	m5 4	Laxe	Eas	ton	MD	41601
	Sta Registi		31. Date filed (Month PR Year) 2	009 32/2	egistrar's Sigr	natura 6	asid						
	negisti	वा	DAME FOR THE STATE OF THE STATE		•	0							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-02943 State of Maryland / Department of Health and Mental Hygiene George Meekins Certificate of Death 1- For State Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day April 13, 2009 1027 hrs Medical Examiner SON Deorge 4c. County of Death 4a. Facility Name (if not institution, give street and number) Town, or Location of Death Dorchester Cambridge Dorchester General Hospital 8. Date of Birth(MM/DD/YYYY 9. Birthplace (State or If Under 1 Year | If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number Foreign Maryland **Funeral** Hours Min Davs Months Director 9-56-8384 1 M Usual Residence of Decedent 10d. Inside City Limits Oc. City, Town or Location 10b. County Yes 2 V No or items 23a or 28a-f show must be notified at once. hours after death with the Maryland Director 10g. Citizen of What Country' 10e Street and Numbe 000 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. 11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 2 Married Never Married 2 No Black Yes Yes 2 No specify: Specify: Yes, Give Yeer Divorced Widowed Examiner 3 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Pages I and 2 should be filed within 72 I nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "I or other traumatic event, the Medical E 21215-0036 icensed Practical 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ober +S Meekins II Manzella Harrison TEOY9E 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Re tionship (Type, Print) Aire45 Baltimore, MD Barbara City or Town, State 20b. Place of Disposition (Name of cometery, Date 20a. Method of Disposition Removal from State Cremation 3 109 1 V Burial 2 18 ordtown Cemetery ambr Important: injury or oth Other Specify Donation 5 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Home, P. HENRY FUNERAL Str Cambridge, 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and **Physician** failure. List only one cause on each line Death Medical a Atherosclerotic cardiovascular disease complicated Immediate Cause (Final disease .aminer Due to (or as a consequence of): by hypothermia or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examiner (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed and Physician/Medical AMENDED 23a,27,28a-f,perME, g891 5/20/09 TT X UNPENDED e attending physician for use as the burial -23d. Date of delivery Box 68760. 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year Fetal death Live birth Pregnant at time of death Other (Specify 5 1 Yes 2 No 9 Unknown 9 the signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. Yes 2 No 3 Probably 4 ✔ Unknown þ Completed 24b. Were autopsy findings available 24a Was an certificate has been a ector, page 2 should prior to completion of cause of autopsy death? performed? 1 🗸 Yes 2 No ✓ Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical funeral director, Be Division of Vital Other₄ examiner? Hospital: 1 Residence 6 DOA Inpatient 2 V ER/Outpatient 3 After this 1 🗸 Yes No 28d. Describe how injury occurred subject exposed to cold 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury (Month, Day, Year 27. Manner of Death Certification: Yes 2 X No Natural Pending Fd 4/13/09 Fd 6:01 <u>environment</u> 24 hours after death. filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 5 3 50 Airey's Rd Cambridge, MD 2 X Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be 3 Suicide determined (Specify) Yard of house Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical

within 24 hor

To the Fune

completely fi

29b. Signature and title of certifie

31. Date filed (Month, Day)

Theodore M. King, Jr., MD.

32. Registrar's Signature

Assistant Medical Examiner

and manner stated

30. Name and address of person who completed cause of death (Rem 23a)

16 2009

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

OCME

29d. Date signed (Month, Day, Year)

April 14, 2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Evelyn May Miller /Medical April 2009 9:40 AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Talbot Genesis HealthCare The Pines Easton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number **Funeral** Days 1 □ M 2 🔀 F Director 98 27, 1910 Maryland 214-01-4901 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be nothed at Director MD 1 XYes 2 □ No Talbot Easton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 610 Dutchmans Lane 21601 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2√□No Specify: ģ Specify: white 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 9 12 should be filed w th and Mental Hygie 7 is marked other ti 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked any linjury or other traumatic ewore. Charles Monroe Todd Ada Mills ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Jones sister 2729 Toddville Rd., Toddville, MD 21672 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Maryland Veterans Cem 4/3/09 Hurlock, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. the both long 700 Locust St., Cambridge, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** culure disease or condition resulting in death) /Medical (or as a con equence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the attending physician and hed for use as the burial-tran Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autop performe 1 ☐ Yes 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physiclan: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicial. the Funeral Director:

29b. Signature and title of certifier

ROWLEY

Name and address of person who completed cause of death (Item 23a) (Type, Print) MICHALL MD

DUTCHMANS 610

State Registrar

Medical

(Check only one)

and manner stated.

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 4 2009 3:00 A Vurces /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Atlantic General Hospital Berlin Worcester 7. Age (In yrs. last birthday)
70 Yrs. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Days Hours 4 /10 1938" MD 212-34-4587 Director Usual Residence of Decedent 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it e Wedlest Exercises must be notified at 1 XYes 2 No Director Worcester MD Ocean City 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 11 Philadelphia Ave. #2 21842 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 ☐ Never Married 2 X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: white ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Crisis Minister Religion 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be h and Mental I William Bishop Ella May Kerns 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health as Important: If item 27 Is any injury or other trau 12913 Horn Island Dr., Ocean City, MD 21842 Michael D. Meyer / son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State Sunset Memorial Park: 4/10/2009 Berlin, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Burbage Funeral Home 21. Signature Funeral Service Licenses 108 William St., Berlin, MD 21811 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Wo carlial disease or condition resulting in death) /Medical Due t (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last (or as a consequence of): burial-tra the attending physician hed for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 Z No Month Day 4 Pregnant at time of death 9 Unknown After this certificate has been signed by funeral director, page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 No 1 ☐Yes 2 ☐ No ivision of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gateway Suite SH Ocean City, prd. 21842 BA3 31. Date filed (Month, Day, 32. Registrar's Signature Registrar

DHMH 17 Rev 1/2001

TOD: 0300

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Earl Jones Outten /Medical March 2009 8:50 p 4a. Facility Name (If not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death Examiner Chesapeake Woods Center Cambridge Dorchester 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Days 1 M 2□ F 214-32-0364 Director 80 8, 1928 Maryland Usual Residence of Decedent death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Widcal Event it we must be prufficed and once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits MD Dorchester Cambridge Director 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1200 Hambrook Blvd. 21613 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 Married Baltimore. Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify 2 Specify: white 3 ₩ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) supervisor seafood processor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Maurice J. Outten Sadie F. Elliott 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katherine O. Koski daughter 108 Richardson Dr., Cambridge, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/6/09 Dorchester Mem. Park Cambridge, MD 21. Signatu re of Funeral Servi ce Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 2 weks disease or condition resulting in death) St (idium /Medical ue to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 □Yes 2 □ No 9 Unknown 9 Tillnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Linknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 【 NO Hospital or Attending Physician: 24 hours after death. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Designation of Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this Certification: To 27. Manper of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No Accident Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical (Check only nd manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RR 12.0 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

09-02677 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Kenneth Allen Opfer 1. For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Da April 5, 2009 Year Medical Examiner KENNETH ALLEN OPFER 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Oakland Garrett Garrett Memorial If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min Director 198-66-1512 29 JULY 3, 1979 1**X** M 2 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County or items 23a or 28a-f show must be notified at once. PENNSYLVANIA GREENE GARARDS FORT within 72 hours after death with the Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö 719 MAPLETOWN ROAD 15334 UNITED STATES Funeral 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. 1 X Never Married 2 Married Yes 2 X No f Yes, Give Year Yes 2 X No specify: Specify: Widowed 4 Divorced "natural", à 16a. Decedent's Usual Occupation (Give kind of work done 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) , MD 21215-0036 and 2 should be filed within 72 lalth and Mental Hygiene. the Medical Mental Hygiene. marked other than TRACK ENGINEER RAILROAD 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be KENNETH OPFER PAMELA WEST Pages 1 and 2 should lent of Health and Me (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) item 27 is 719 MAPLETOWN ROAD, GARARDS FORT, PA 15334 KENNETH OPFER/FATHER 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition APRIL 11, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 2009 MONONGAHELA CEMETERY MONONGAHELA, PA Donation 5 Other Specify 9 22. Name and Address of Facility FELLOWS, HELFENBEIN AND CREMATION AND FUNERAL CARE, P.A., 814 I ROAD, ANNAPOLIS, MARYLAND 21401 21. Signature of Funeral Service Licensee Will Exon M00672 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line /Medical a. Drowning Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and cal g physician a UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown

Time of Death

0227 hrs

9. Birthplace (State or Foreign

10d. Inside City Limits

Yes 2 X No

Approximate Interval

Between Onset and

Death

Year

No

29d. Date signed (Month, Day, Year)

April 5, 2009

PENNSYLVANIA

Country

WHITE

Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be led by the attending has been page certificate this death. Director: filled in by the

ğ

Completed

Be

Medical

29b

23d, Date of delivery 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 V No 3 Probably 4 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? 1 🗸 Yes ✓ Yes 2 26.Place of Death (Check only one) 25. Was case referred to medical examiner? Other₄ Hospital: 1 Nursing Home 5 Residence 6 Inpatient 2 V ER/Outpatient 3 1 Yes No 28a. Date of Injury (Month Day,Year) Apr 5, 2009 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Passenger in auto that overturned into pond 0030 hrs Natural Pending Yes 2 V No 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be Suicide or Town, State) Sang Run Road / Barbara's Lane , McHenry , MD determined (Specify) Pond Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

To the 1

Name and address of person who completed cause of death (Item 23a)

OCME

and manner stated

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Laron Locke MD.

37. Registrar's Signa

31. Date filed (Month Day 8 r) 2009 State Registra

ORIGINAL

29a. Certifier (Check only

Signature and title of certifie

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0 9

			For State Registrar	State of M		d / Dep	artment of h rtificate of	Health :		lental Hygi			13060
			1. Decedent's Name (First, Middle, L	.ast)						2. Date of Death Month		Year	3. Time of Death
	Physicia /Medic		Charlotte Hu	lda	Potzner	r				April 6,	2009	Todi	4:35а м
	Examin		4a. Facility Name (If not institution, g	ive street and number	7)		4b. City, Town, c	r Location	of Death		4c. County of	of Death	
			Bedford Court Assis	ted Living			Silver	Spring	3		Montg	omers	7
	Funeral Director		577-18-6621	Sex 7. A	ge (In yrs. i	97 Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, October 7,	Year) 1911	9. Birthi Coul	place (State or Foreign ntry) Germany
	p .		Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Lo	ncation					1	Od. Inside City Limits
	aryla shor	<u>ا</u>	Monton	erv	100.00	y, TOWN OF EX	Silver Spr	ina					1 □Yes 2 X No
	28a-f	ect	T.E.				10f. Zip Code			10	g. Citizen of W	hat Cou	otry?
:	a or i	Funeral Director	10e. Street and Number 3700 International	Drive, AL 34	45			0906			USA		in y .
,	s 23	eral		12. Was Decedent		C 12	Was Decedent of h	lienanic Or	igin2 (Sp.	acify Vas or No.	14 Bace	- Ameri	can Indian,
	item item	Ë	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces	?	3.	Was Decedent of I If Yes, specify Cub	an, Mexica	n, Puerto	Rican, etc.)		, White,	
გ ე	rs aff	by	3 XWidowed 4 □ Divorced	1 ∐Yes 2 √2 If Yes, Give Year or Dates:	K."		1 □Yes 2\1\1\1\0	Specify:			Specify:	Wh	nite
ڄ _ا	tura stura	ed	15. Decedent's	Education		16a. Dece	dent's Usual Occu	pation		1	6b. Kind of Bus	siness/In	dustry
212	in 72	plet	(Specify only highest of Elementary/Secondary (0-12)	grade completed) College (1-4or	E.\	(Give	kind of work done DO NOT use retire	during mos d)	t of worki	ing	Own	Home	
717	with giene r tha	Completed	12	College (1-40)	5+)	Hon	nemaker				OWII	LIGHT	_
פ	be filed within 72 hours after death with the Maryland the Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at	Be C	17. Father's Name (First, Middle, La	st)						(First, Middle, M	aiden Surname	9)	
<u> </u>	should be filed and Mental Hygi s marked other umatic event, II	To	Max Lademacher					r	ıınna	Stoeckel			
Maryland 21215-0036	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic evonce.		19a. Informant's Name/Relationship			1	ng Address (Street						o Code)
Σ	and and sealth		Suzanne C. Hasenpusc	h / Daughter			Wintergree		#40	<u> </u>	·		
ore.	of He		20a. Method of Disposition	□ Damaral from State	20b. F	Place of Disperentery, cre	osition (Name of matory or other pla	ce)			0c. Location - (-	
Ĕ	Pag ment mant: I		1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		" Park	slawn Me	emorial Par	k A	oril 1	11, 2009	Rockvill	e, MI	
Baltimore,	porti		21. Signature of Funeral Service Lic	ensee		2	2. Name and Addre Francis J.			normal Homo	Tna		
m	89 = 89		Allson	Arevalo		1	500 Univer	sity B	Lvd. V	West, Silve	er Spring	, MD	20901
			23a. Part 1. Enter the disease, or co shock, or heart failure. List on	mplications that cause	ed the deatl	h. Do not en	ter the mode of dy	ng, such as	cardiac	or respiratory arre	st,		Approximate Interval Between
F	Physician		Immediate Cause (Final disease or condition				Failure						Onset and Death Months
	/Medical		resulting in death)	Due to (or a			Larran						
·	Examiner		Coguantially list conditions	b									
	p , <u>⊨</u>	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated exerts	Due to (or a	s a consequ	uence of):							
	ecute ind trans	am	Cause (Disease or injury that initiated events resulting in death) Last	с									
,60	eath certificate be executed attending physician and for use as the burial-transit		resulting in death) Last	Due to (or a	s a conseq	uence of):							
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	certifical oding physe as the	Physician/Med	IF FEMALE:	22a If yes sutsom	o of progns	anou.							
Box	ath c	ian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom	2 🗆 Feta	death 3	Ectopic pregnan	су			23d. Date Mor		ery Day Year
o j	the g	/sic	1 □Yes 2 🛣 No 9 □ Unknown	4 □ Pregnant 9 □ Unknown		ieath 5	Other (specify)						
.	The law requires that the death ate has been signed by the atter age 2 should be detached for un		Part II. Other significant conditions	contributing to death	but not res	ulting in the u	Inderlying cause gi	ven in Part		23e. Did tob	acco use contr	ibute to t	the cause of death?
Records,	signe	d b	Renal Failure	Ů		Ü	, ,			1 □ Ye	s 2 No	3□ Pro	bably 47 Unknown
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ě	elaw has je2s	μ								24a. Was ar autopsy perform	/ p	rior to co leath?	opsy findings available ompletion of cause of
				_						1 □Yes 2	No 1	□Yes	2 🗷 No
Vital Vital	certif rector	B	25. Was case referred to medical examiner?	Hospital:			[Ot	har-		h (Check only one			
5	Phys rthis ral dii	<u>ب</u>	1 ☐ Yes 2XXNo 27. Manner of Death	1 ☐ Inpa		ER/Outpatie	all SI DOX	4 ⊔ N	ursing Ho	ome 5 Reside			ify)
<u>ا</u>	or Attending Physician: ifter death. Director: After this certific. in by the funeral director,	ië	1 X Natural 5 ☐ Pending	(Month, D	day, Year)	Injury	Wo	rk?]Yes 2□	INo	Log. Dobbildo ilo	ir injury occurr		
2	otor: y the	ica	3 Suicide 6 Could not	be 280 Place of I	niury - At ho	l ome, farm, st	reet, factory, office			28f. Location (Str	eet and Numbe	er or Rur	al Route Number,
Division of	or A after Dire	Certification:	4 ☐ Hornicide determine	building,	etc. <i>"(Specil</i>	fy)	,,			City or Town	, State)		
_	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Af completely filled in by the fur			Physician: To the besi									
	the H iin 24 he Fu iplete	Medical	one)	aminer: On the basis and manners	stated.	andi and/of l	investigation, in my	opinion, de	aui occul				
i	To to the second	Σ	29b. Signature and title of certifier	11/	//	11	29c. Licen	se number	10-	29	d. Date signed		
	$l_{\mathcal{D}}$		▶ V/	[]		W	リリ	707	> /		April	0, 20	W3
			30. Name and address of person w	o ompleted cause of	death (Iter	n 23a) (Type	, Print)						
			Nakul Goyal, M.D				ional Drive	#211,	Silve	er Spring,	MD 20906	, ,	
	Sta Registr		31. Date filed (Month, Day, Year) APR 09 2	009 Och	strar's Signa	1. Apa	well						

3 Time of Death

Physician /Medical Examiner

Funeral

Director death with the Maryland th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-1 shov traumatic event, the Medical Examinar must be notified at Director Funeral Pages 1 and 2 should be filed within 72 hours after ģ Completed Be ၉

Health а permit. Pages 1 and 2 Department of Health Important; If Item 27 any injury or other tra once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Examine

Physician/Medical

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Completed

Be

Certification: To

Medical

State

Registrar

09

APR

Hospital or Attending Physiclan; The law requires that the death certificate be executed burial-trai physician the attending p for use as t sate has been signed by the page 2 should be detached this certificate director, After 1

24 hours after death. filled in by the within 2 To the I the ٥ 10

Division of Vital Records, P.O. Box 68760,

^{Day}2009 April 7, 5:13 P_M Pike Morris 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Bedford Court Assisted Living Silver Spring 6. Sex 1 M 2 □ F If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month Day Year March 21, 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Months Days Hours Min. 1927 Massachusetts 82 003-18-4483 Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City. Town or Location MD Montgoemry Rockville 1X Yes 2 □ No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 20853 14105 Parkland Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No WW-II If Yes, Give 14. Race - American Indian Black, White, etc 1 Never Married 2 Married Specify: White 1 ☐Yes 2X No Specify: 3 Widowed 4 Divorced Ye ar or Dates 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) General Electric 4 Computer Programmer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leslie Pike Marion Levin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 14105 Parkland Drive Rockville, MD 20853 Dorothy Pike-Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from State 04/10/2009 Olney, MD Judean Mem. Grdns. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Edward Sagel Funeral Direction, 21. Signature of Funeral Service Licenses 1091 Rockville Pike Rockville, MD 20852 Inc. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Years Metastatic Prostate Cancer disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Day in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Renal Insufficiency 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 24 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie April 8, 2009 D08381 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Benjamin Avrunin, MD 3305 N. Leisure World Blvd. Silver Spring, MD 20906 Benjamin Avrunin, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 11:20a M 2009 Martha Young Pettus 28 March /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Chevy Chase Manor Care Chevy Chase Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Min 1 □ M 2 🕱 F Yrs. July 21, 1927 Ohio Director 577-32-8778 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ " any illury or other traumatic events any illury or other traumatic events." 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 ☐ Yes 2 X No Director Montgomery Silver Spring Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number II.S.A. 20904 531 Randolph Road, #111B Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 1 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🖾 No Specify: Specify: \$ Caucasian 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ Caroline Elizabeth Fretague ပ Arthur W. Young 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Cheryl Easton Lowe - Niece 2260 Golf View Lane, Hampstead, Maryland 21074 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 04/13/2009 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Crematory 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Hines-Rinaldi Funeral Home, Inc. nen 11800 New Hampshire Avenue, Silver Spring, Haryland 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ONGE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed the burial-trai Due to (or as a consequence of): Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? cate nas been signed!; page 2 should be deto Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 **S**AB 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Matural 5 Pending investigation 1 ☐Yes 2 ☐ No 24 hours after death. Funeral Director: A 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical completely (Check only and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 20057124 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

Box 68760,

P.0.

Records.

Division of Vital

Truong Bao, M.D., 10110 Molecular Drive, Suite 206, Rockville, Maryland 20850

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** a 2009 orraine /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Care orches 24 Hrs rs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Min. 1 □ M 2 🗹 F Months Days Director Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 27 is marked other than "natural", or Items 23a or 28a-f shows traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 PNo Funeral Director orche 10g. Citizen of What Country? 10e. Street and Number 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. <u>۾</u> 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) State Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be of Health and Mental Dorothy ٩ Iravens 19b. Mailing Address (Street and Number or Rural Role Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1331 34Taylors Island Rd. Department of Health Important: If item 27 any injury or other trong. Woolford, Maryland 21677-20c. Location - City or Town, State hamas 20b. Place of Disposition Name of cemetery, crematory or other place) Date 20a. Method of Disposition 4 □ Donation 5 □ Other (Specify)

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Henry Funeral Home, Ret

32a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1 ■ Burial 2 Cremation 3 Removal from State Taylors Island ADD MD. 21613 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) BRAST tastatic 48A1 **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ Month Day Year Pregnant at time of death 5 Other (specify) certificate has been signed by the irector, page 2 should be detached 9 Unknown 9 Unknowf 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ombe 3 Derobably 4 ☐ Unknown 1 Tyes 2 🔲 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy HINKI 2 🕽 247 1 ☐ Yes 1 ☐ Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 NO Hospital: Other: 4 Surviving Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Terrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier Date signed (Month, Day, Year)

Registrar

State

30. Name and add

ess of person

APR 06

L013 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

ho completed cause of death (Item 23a) (Type, Print) D.D.

Registrar's Signature

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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month **Physician** 11:50 pM Chong Chul Rhim April 06 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 **X** M 2 □ F South Korea Director March 10, 1942 219-02-9009 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 440 E. University Blvd., #216 20901 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Inportant: If item 27 is marked other than "natural", or iter amy Injury or other traumatic event, Ire Medical Examines and. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ♣ No Specify. ρ Specify. 3 Widowed 4 Divorced Asian Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Carpenter Home Improvement 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Moo-Duk-Yi Choi Hak-Woon Rhim 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bok Soon Rhim - Wife 400 E. University Blvd., #216, Silver Spring, Maryland 20901 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 04/09/2009 4 ☐ Donation 5 ☐ Other (Specify) Norbeck Memorial Park Olney, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. Alkle 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Hypotension 1 day /Medical Due to (or as a consequence of): Examiner Sepsis 1 day Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed 2 days burial-trar Pneumonia Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical the as attending for use as 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ≦ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🙀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed certificate 1 ☐Yes 2 No 1 ☐ Yes 2 ☐ No 24 hours after death.
Funeral Director: After this certific etely filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature a MD D66416 April 6, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 Hospital Drive, Cheverly, Maryland 20785 Sujatha Ramaseshan, M.D., 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 09 Registrar

217-07-7208 Red March Re			For State of Maryland	I / Department of Health and Certificate of Death	Mental Hygie Reg.	21119 131165
## Special Name of the Name of					Month	Day Year
To Caroline Preston 100. Caroline	Examin Funeral		4a. Facility Name (If not institution, give street and number) Envoy of Denton 5. Social Security Number 6. Sex X 7. Age (In yrs. la	Denton If Under 1 Year If Under 24 Hrs Months Days Hours Min	8. Date of Birth (Month, Day, Ye	4c. County of Death Caroline 9. Birthplace (State or Foreign Country)
Min Caroline Preston	Director		Usual Residence of Decedent	9	3/1/1920	
23a. Part I. Erier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock or heart failure. List only one cause on each line. International cause [Freat Freat Fr	Ba-f show	ector	MD Caroline E	reston	100	1 ☐ Yes 2 🖰 No
23a. Part I. Erier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock or heart failure. List only one cause on each line. International cause [Freat Freat Fr	23a or 2 stban	al Dire			Tog.	
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23a Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate cause (final resulting in death)	natic e	TOE				ity or Town State Zin Code)
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart slide. List only one cause on each line. The mediate clause (Final resulting in death) Sequentially isig conditions. Sequentially isig	27 IS IT r treum					
239. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause or each line.	or othe		20a. Method of Disposition 20b. Pl	ace of Disposition (Name of		c. Location - City or Town, State
23a. Part I. Errier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause or each line. 10a	njury o		`4 □Donation 5 □Other (Specify) Ceme	etery 4/1	5/2009 Ba	altimore, MD
23a Part I. Effor the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Blaveen Chast and Death Immediate Cause (Final disease) or condition describing in death). Bequantially list conditions, and interval Blaveen Chast and Death Cause (Disease or intury respiratory arrest, interval Blaveen Chast and Death Chast and	ouce		Hest Clean	Fleegle and Helfer	nbein Funer	ral Home
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use confribute to the cause of death?	ier	Ical	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Little Underlying Cause (Disease or Injury that initiated events	ne-foot sence of): (ca) vascular d		IIIIdi vai Delween
1 Yes 2 PNo 3 Probably 4 Unknow	222	ysician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 2 N	death 3 Ectopic pregnancy		
performed? 1	99	by		ulting in the underlying cause given in Part I.		
25. Was case referred to medical examiner? 1 Yes 2 No	30 2	Complete			autopsy performe	
27. Manner of Death 1 Autural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M Work? 1 Yes 2 No 28c. Injury at Work? 1 Yes 2 No 28d. Describe now injury occurred 28d.	rector	Be	examiner?	Other		ce 6 Other (Specify)
29a. Certifler (Check only one) 29b. Signature and title of certifler 29b. Signature and decrease of person who completed cause of death (Item 23a) (Type. Print) 30. Name and address of person who completed cause of death (Item 23a) (Type. Print)	uneral		27. Mannarot Death 1 Natural 5 Pending (Month, Day Year)	28b. Time of lnjury at Work?		
29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year)		ertifica	3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury · At ho			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Melicida Butter 136 Lednum Are Preston MD 21655	ətəly fillə		(Check only 2 Medical Exeminer: On the basis of examinal	wledge, death occurred at the time, date and pla- tion and/or investigation, in my opinion, death oc	ce, and due to the cau- curred at the time, date	se(s) and manner as stated. a and place, and due to the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Malice de Butter 136 Lednum Are Preston MD 21655	compi	Me	29b. Signature and title of certifier	7.1		Date signed (Month, Day, Year)
State 31. Date filed (Month, Day Year) 2009 32 degistrar's Signature.			30. Name and address of person who completed cause of death (Item Maling de Butter 134 Ledin	23a) (Type, Print)		455

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Physicia	_	Registrar 1. Decedent's Name (First, Midd	le,Last)	- 001	tineate or	Dodin		2	. Date of Dea				e of Death
il Exami		Michael	Paul	Sor					Month April 6, 20		Year		22 hrs
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Eurosal		5. Social Security Number		7. Age (In yrs. ia	ast hirthday)	If Under 1 Yea		24Hrs.	8. Date of Bir				(State or Forei
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Ment Ment mark	10	19a. Informant's Name/Relations			19b. Mailing	Address (Stre	et and Numb	ber or Ru	ral Route Nur	mber, City o	r Town, S	tate, Zip C	ode)
d 2 sh Ith and n 27 is		Anna T. Sorb	er (Mother			Old Fort				gton,	Mar	yland	20744
s I an of Hea If iter		20a. Method of Disposition 1 X Bunal 2 Cremation	n 3 Removal fro		Place of Disposi crematory or oth	tion (Name of ce er place)			Date 1 14,	20c. Loc	ation - Cit	y or Town,	State
Page ment fant: or ot		4 Donyation 5 Other S	pecify:			ion Ceme	tery	200		C1i	nton	Mar	vland
ermit bepart mpor ijury		21. Signature of Funeral Services Servi	00	0139	1	ame and Addres		7,0	e Fune	ral H	ome,	Inc.	
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	dica	UNPENDED	AMENDED										
ires that the death certificate be executivising by the attending physician and be detached for use as the burial - trans	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in t	ho	utcome of preg	nancy		<i></i>				ate of del		
ending use as	cian	past 12 months?	L Live bi	rth ant at time of de	ath	tal death 3 ner (Specify)	Ectopic	pregnan	су	Mo	nth	Day	Year
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that the	by P	Part II. Other significant condi	tions contributing to	death but not r	esulting in the u	nderlying cause	given in Par	rt I.					use of death?
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After this funeral dir	. To	1 ✓ Yes 2 No 27. Manner of Death	28a Date	npatient 2	ER/Outpatient 28b. Time of I		ury at Work?		28d. Describe			Julier. Sceni	· -
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. No thin 24 hours after death. To the Function: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri		29a. Certifier 1 Certifying P	Physician: To the best aminer:On the basis o	of my knowled	ge, death occur	red at the time, o	late and place	ce, and c	ue to the cau	se(s) and n	anner as	stated.	P(S)
You withi You comp	Medical		and manner st	ated.			n, death occ se number	Juned at	ure ume, date			(Month, Da	
	2	29b. Signature and title of certifi	1/1	221			.M.E.				, 2009	uviolitii, Da	y. 1 odi j
		Mund	anelf, 1	10	220)					, ,,,,,	,		
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2		30. Name and address of person Melissa Brassell, MD	n who completed caus Assistant Med	·		enn Street,	Baltimore	, MD 2	1201				

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		1	State of Maryland / Department / Department / Department / Department / Department / Department	artment of Health and Me ctificate of Death	ental Hygier	2005 13001	
	Physicia	an	1. Deaedent's Name (First, Middle, Last)	TOWE	2. Date of Death Month	3. Time of Death	
,	/Medic	_	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	-	c. County of Death	
	Examin	Ç.	Anne Arundel Medical Center	Annapolis		Anne Arundel	
	Funeral		5 Social Security Number 6. Sex. 7. Age (In yrs. last birthday)		B. Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign Country)	
Ш	Director		057-26-7065 17 M 2□ F 73 Yrs.	Months Days Hours Will.	7/15/193	NY	
	ס	-	Usual Residence of Decedent			10d. fnside City Limits	
	how	Director	10a. State 10b. County 10c. City, Town or Lo MD Anne Arundel Edgewat			1 Tes & No	
	e Ma		MD Affile Affilider Edgewar				
	death with the Maryland ms 23a or 28a-f show rmust be notified at		10e. Street and Number	10f. Zip Code	10g. (Citizen of What Country?	
	23a	al	3942 Germantown Rd.	21037		USA	
	r dea	Funeral		Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto R	ity Yes or No- ican, etc.)	14. Race - American Indian, Black, White, etc.	
စ္က	or H		1 Never Married 2 Married 1 Yes 2 No If Yes, Give	1 ☐ Yes 2 🖾 No Specify:		Specify: White	
ğ	ural	d by	3 ☐ Widowed 4X Divorced Year or Dates:	dent's Usual Occupation	166	Kind of Business/Industry	
2	"net	ete	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	kind of work done during most of working DO NOT use retired)	9	Tanco di Basinesa in Lang	
2	withir ane. then	To Be	Elementary/Secondary (0-12) College (1-4or 5+)	ıstrator		Medical	
2	permit. Tages I and a should be filled within 12 flours after death with the maryan important and fleatilk and Mantal Hyginale. Inspectment if item 27 is marked other then "netural", or items 23a or 28a-1 show any injury or other traumatic event. It a Medical Examiner must be notified at once.		17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Maid		
Maryland 21215-0036			Charles Stone	Marion Eg	gleton		
2	hould d Me mark matig		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)				
<u>8</u>	d 2 s th ar trau trau		Donna Selby Friend 3942 Germantown Rd. Edgewater, MD 21037				
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Baltimore,	it. Partme			2. Name and Address of Facility Hard			
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			23a Part Foter the disease or complications that caused the death. Do not en			Approximate	
	Ц.,	er	/sylock, or heart tallure. List only one cause on each line.				
	Pnysician /Medical		resulting in del. Due to (or as a consequence of);		1 2 00 0		
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of Vital R					24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of	
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	ing Phys n. After this funeral dii						
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<u>Vis</u>	or Attendatter death	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	8f. Location (Stree City or Town, S	t and Number or Rural Route Number, tate)	
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	elect,	٢	1000	Drint)	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	10 m 0 - 12001	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar APR 0 8 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANN MOUS MD2/40 31. Date filed (Month, Day, Year) APR 0 8 2009 Apr 0 8 2009						s M prixo 1	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) APR 08 2009 32. Registrar's Signature	iale			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) April 2009 0755 Harry Steven Steele 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Harford Havre de Grace Harford Memorial Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Months Days 1**火** M 2□ F 81 March 10,1928 Maryland 193-20-4732 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County 1X Yes 2 □ No Havre de Grace Harford Maryland 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 21078 U.S.A. 611 Chapel Terrace 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If ¥es, Give Year or Dates: 1 946-49 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐Yes 2 X No Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Aberdeen Proving Ground College (1-4or 5+) Elementary/Secondary (0-12) Aberdeen, Maryland Electrical Technician Eleven Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Harry Steele Lucretia Sutor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21078 611 Chapel Terrace, Havre de Grace, MD (wife) Mary DePolo Steele 20b. Place of Disposition (Name of cemetery, crematory or other place)

Harford 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from State 04/11/09 Aberdeen, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Memorial Gardens
22. Name and Addre Lee A. Patterson & Son Funeral Home, P.A.
Perryville, Maryland 21903-0766 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pneumonia 1 Week Due to (or as a consequence of): Congestive Sequentially list conditions, if any, loading to infline dide cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for sala consequence of) Cormany Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death 3 🗆 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ※ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 1 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) 2 1 1 Inpatient 2 ER/Outpatient 3 DOA 1 🗌 Yes 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? (Month, Day, Year) Injury 1 Natural 2 ☐ Accident 5 Pending investigation 1 □Yes 2 □ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Examiner and burial-tran P.O. Box 68760. attending physician certificate be the Records, Fee P Plany Division of Vital To the Hospital or Attendi within 24 hours after death. To the Funeral Director; A

its certificate has been signed by the director, page 2 should be detached filled in by the

Physician

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Physician /Medical

Maryland 21215-0036

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Certification: To

Medical

or other traumatic event, the Medical Examinar hast be notified at

HHIVA

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

4 - Homicide

29a. Certifier (Check only one)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

HAVRE de GRACE MD 21078

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State Registrar Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed anding physician and use as the burial-tran signed by the a this certificate After death. i Director: d in by the after within 24 hours a To the Funeral C

Physician

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any lijury or other traumatic event, the Marchal Evinture contact and page.

Baltimore, Maryland 21215-0036

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3 ☐ Suicide

29a. Certifier

4 Homicide

12

State Registrar HN14 07 Rev 1/2001

29b. Signature and title of certifier & CarlliMD 29c. License number P22077

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) april 07, 2009

28f. Location (Street and Number or Rura! Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) South Greene Street Baltimore MD 21201 Agcaoili CECILY

and manner stated.

32. Registrar's Signature 31. Date filed (Month, Day, Year)

6 ☐ Could not be

determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day /L Year **Physician** 34 AM Donna Kaue Wolfe 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington County Hospital Washington Hagerstown If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 Z F 55 21, 1953 213-50-0205 July Pennsylvania Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2√ No Director Cascade Maryland Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5 14504 Water Company Lane items 23a 21719 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 14. Race - American Indian. 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iten any Injury or other traumatic event, the Medical Examinations. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: ģ White 3 Widowed 4 Divorced Be Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Church 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Helen V. Gladhill Calvin G. Pryor, Jr. ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) (Husband) 14504 Water Company Ln. Cascade, Maryland 21719 N. Leon Wolfe, Jr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition April 22. 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Smithsburg, Maryland Smithsburg Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2009 J.L. Davis Funeral Home 22. Name and Address of Facility 21. Signature of Funeral Service Licensee MO1414 12525 Bradbury Ave. Smithsburg, Maryland 21783 23a. Part Email the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Morendik Yeard disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been slaned by the attending whosis and attending physician and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ⋧ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐ Yes 2 ☐ No 2 🗆 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 4.17.09 41667 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical Compos Hegerstown M661 Registra s Signature State

Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. / 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** RALPH YOUNG 8:55 D M APRIL 10 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** CENTER MERCY MEDICAL BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** XXM 2□ F Months Days Yrs. **Director** 80 220-24-9265 July 26, 1928 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State show ral", or items 23a or 28a-f shor Examiner is ust be notified at XXYes 2 □ No Directo Cecil Maryland Rising Sun the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with to Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 2 may injury or other traumatic event, the Medicel Examinar must be nobe. 21911-2252 100 McNamee Lane United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 □Yes 2↓No If Yes, GiveXX Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify. Completed by Specify: White 3 ☐ Widowed 4 🗷 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) United States Elementary/Secondary (0-12) College (1-4or 5+) Contractual Inspector Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be Ralph W. Young Dorothy V. Storey မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lois E. Young / Ex-Wife 634 Beards Hill Road, Aberdeen, Maryland 21001 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition April 14, 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify
21. Signat 5 Other (Specify) 2009 Baltimore, Maryland Woodlawn Cemetery 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland21901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) METASTATIC RECTAL CANCER MKnown **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Examir that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has treetor, page 2 s autopsy 1 ☐Yes 2 No 2 X No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 28h Time of 27. Manner of Death 28a Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation (Month, Day, Year) Injury Natural 2 Accident ours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie To the Hosp within 24 hou To the Fune completely fi 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number WD 1083816987 APRIL 10th . 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year) APP 1 9 2009

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ST. PAUL STREET, BALTIMORE, MD, 21202 32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #18 per FH G890 4/28/09 TT
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death APRIL 200 Josefina R. Arroyo 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Randallstown Baltimore Seasons Hospice If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex Months Days Hours 1 □ M 2 🛣 F Yrs 577-74-5915 95 Dec.14,1913 Philippines Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2 XNo Maryland Baltimore Windsor Mill 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1 Topview Court 21244 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ※No 11. Marital Status 1 X Never Married 2 ☐ Married SpecifyPacific Islander If Yes, Give Year or Dates: 1 ☐Yes 2 No Specify 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Antonia Antonio Jesus Arroyo, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marcela Quinones Niece 1 Topview Court; Windsor Mill, MD 21244 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4/25/2009 Atlantic Crematory Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Facility Sterling Ashton Schwah Witzke 21. Signature of Funeral Service Licensee MO1050 Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 Hukma 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final STATUS EPILLEPTICUS disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Ulnknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Ø Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy 2 1 No 1 Tyes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother Specify 105 PICE Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred

Physician /Medical Examiner and

Physician

/Medical

10a, State

Director

Funeral

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Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "Medical Evant extraust be notified at once.

Baltimore, Maryland 21215-0036

Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar attending physician as the signed by the a icate has been si, page 2 should b ral Director: After this c To the Hospital within 24 hours a To the Funeral C

Division of Vital Records, P.O. Box 68760,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician/Medical IF FEMALE 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ş Completed Be 25. Was case referred to medical examiner? 1 Yes 2 No Certification: To 27. Manner of Death 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide completely filled 29a. Certifier Medical and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

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State Registrar 31. Date filed (Month, Day, Year) APR 2 4 2009

address of person who completed cause of death (Item 23a) (Type, Print)

DDIG BUTON 2835 Smith the Suite 203 Baltimore MP 37. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Ahalt **Physician** 8.05AM Pauline 2009 /Medical April 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ellicott City Nursing & Rehab Ellicott City Howard 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕅 F Months Days Hours 213-20-5351 89 Director Oct 25 1919 PA Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-6 charm any linury or other traumatic event, the Medical Experiment 2000. 10c. City. Town or Location 10a State 10b County 10d. Inside City Limits MD Howard Columbia 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11910 Yellow Rush Pass 21044 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 ☐ No Specify. Specify: white 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) health care licensed practical nurse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nicholas Prebish Zenia Kozlick P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janis Ahalt Riker (daughter) 11910 Yellow Rush Pass, Columbia, MD 21044 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation:4-24-09 Sykesville, MD 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee ▶ Page Haight Herbert P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Alhensclerolic DIRCURE Cardiovascular **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Multimbarc Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed g physician and as the burial-trans Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 ☐ Yes 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No cate has I page 2 s autopsy 1☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 1 Yes 2 No P 1 Inpatient 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) i Director: After to d in by the funera 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Tes 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical

Division or Vital Records, P.O. Box 68760分 To the Hospital or Attending Physician: within 24 hours a To the Funeral L

> State Registrar

29b. Signature and title of certifier

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30641

29d. Date signed (Month, Day, Year)

River Neck Road Baltimore Meriland 21221

April 23 2005

and manner stated.

201-109

Registrar's Signa

30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Ramech Schapalm 201-109 Back

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month . Horung **Physician** arul /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number, **Examiner** 14h & Kehabilitatio 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 1 M 2 M 2:15-1 Director 10d. Inside City Limits and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location State 10b. County of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Marken Expriment must be molffied at 1 ☐Yes 3€No Funeral Director 10g. Citizen of What Country? 10e. Street and Number 1206 melia Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 Tes No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Completed by 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) y/Seconda)y (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden 2 19b. Mailing Address (Street and Number or Rural Route Number, permit. Pages 1 a Department of He Important: If item 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) any injury or 21. Signature of Funeral Prvice Licensee mo or complications that caused the death. Do not enter the mode of dying 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequent **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, cate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 ☐ Yes 2 1 Tyes 26. Place of Death (Check only one) director, 25. Was case referred to medical examiner? Other: 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 X Natural 2 Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 🗌 Suicide determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

... 29a. Certifier Medical the 29d. Date signed (Month, Day, Year) 29c. License number, 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print RMB SWIE 3FL IRIDURAL 31. Date filed (Month, Day, Year State Registrar

9-02540)
inda Ad	kins

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Physician		Decedent's Name (First, Middle	e,Last)					Month	Day	Year	3. Time of Death 2255 hrs
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	4a	. Facility Name (if not institutio	n, give street and nu	mber)	41	Laurel	ocation of Boa		Prin	ce George	's
	-	41 B Street Social Security Number	6. Sex	7. Age (In yrs. las	st birthday)	If Under 1 Year	If Under 24H		Birth (MM/DD/	YYYY) 9. Birti Foreigi	hplace (State or
Funeral Director			1 M 2 X F	50	Yrs.	Months Days	Hours M	in. Nov 2	1, 195	S Cou	Washington DC
		219-72-2476 sual Residence of Decedent	- A								10d. Inside City Limits
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and show	5 L_		ce George	S Lat	urel	10f, Zip Code			10g. Citizen	of What Cour	ntry?
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OO3 withingiene.	_	7. Father's Name (First, Middle					18.Mother's Na	ame (First, Midd	le, Maiden Su	ırname)	
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	<u>e</u>	William Edwa	ard Horiga	an		g Address (Stree	Glor:	ia Ann N	loney	or Town State	e Zin Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Insportant: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.	2	19a. Informant's Name/Relation Charles Jose	ship (Type, Print)	lor	19b. Mailin 5487	g Address (Stree Sleeping	and Number Dog La	ane Colu	ımbia,	MD 21	.045
MD 1d 2 sho alth and m 27 is	L	20a. Method of Disposition		20b. l	Place of Dispo:	sition (Name of ce		Date		cation - City o	r Town, State
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Baltimore, permit. Pages I an Department of He Important: If ite	-	4 Donation 5 X Other	Specify: in s	ate	22.	Name and Addres	s of Facility		** "	1	Church
Ball permit Depart Imporinjury		21. Signature of Funeral Service ROTIA LU	S Wade,	Director	r St	ate Anat	omy Bo	1 2 2 1			
Physician	\dashv	23a. Part I. Enter the disease, failuce. List only one cause	or complications that	caused the death	. Do not enter	the mode of dying	, such as cardi	ac or respirator	y arrest, shoc	k, or heart	Approximate Interval Between Onset and Death
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aminer		or condition resulting in death	Due to (or as	a consequence of	of):						
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Division of Vital Records, P.O. Box 68760, Ital or Attending Physician: The law requires that the death certificate by the direct death. **All Director: After this certificate has been signed by the attending physic led in by the funeral director, page 2 should be detached for use as the but	Physician/Me	23b. Was decedent pregnant in past 12 months?		e birth egnant at time of c	2	etal death 3 Other (Specify)		rogitatio)	_		
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Division of Vital Records, P.O. B to the Hospital or Attending Physician: The law requires that the day thin 24 hours after death. To the Theorem of the transcription of the completely filled in by the funeral director, page 2 should be detached.	alc	29a Certifier	g Physician: To the Examiner: On the ba	best of my knowl	ledge, death or	courred at the time	e, date and place nion, death occ	ce, and due to the curred at the time	ne cause(s) a e, date and pl	nd manner as ace, and due	stated. to the cause(s)
To the within To the comple	Medical		and main	ner stated.	II aridror invest		ense number		29d.	Date signed	(Month, Day, Year)
	Ž	29b. Signature and title of ce	ertitler				C.M.E.		Ma	rch 31, 20	09
		30. Name and address of pe	telfeelli 10	cause of death (It	tem 23a)						
		30. Name and address of pe	II, MD Assist	ant Medical E	xaminer	111 Penn Str	eet, Baltim	ore, MD 212	201		
	State	31. Date filed (Month, Day, Y	(ear)	2. Registrar's Sig	nature fav	2)			_		
Regi			2009	eur p.	. par						

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 20 Month **Physician** 8:16 BROWN CHARLES 04 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N Baltimore Good Samaritan Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) VA 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Min. Months Days Hours **X**[**X** M 2□ F Director 8 20 86 229-18-3987 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Expressor must be notified at ¥ Yes 2 □ No Director N/A Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Apt. 216 USA 21239 Belvedere Ave. Funeral 1651 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status 1 Tes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2x 100 1 ☐ Yes XXNo Specify: þ Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Tower Ford Service Tech N/A 12th 7 is marked other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Cammie Brown ပ unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau 1651 E. Belvedere Ave. Apt. 216 Baltimore Louise M. Brown-wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🖾 urial 2 ☐ Cremation 3 ☐ Removal from State Randallstown King Memorial Pk. 4/25/2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MARCH FUNERAL HOME-EAST la 1101 E. North Avenue Baltimore, MD 21202 wan 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) infarction Myocardial **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to Immediate cause. Emer underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 2 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

the Hospital or Attending Physlcian: The law requires that the death certificate be executed Box 68760. attending physician for use as the buria P.O. been signed by the should be detached of Vital Records. certificate has brieged in rector, page 2 s within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Division

the

with

filed within 72 hours after death

1 and 2 should be Health and Mental

Baltimore, Maryland 21215-0036

Charle.

Brown

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number Res-000

29d. Date signed (Month, Day, Year)

04 - 20 - 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600d Samgritan HOSpital 5601 Loch RAVER Blvd, Baltimore, MD 21139

Natallia Maroz 31. Date filed (Month, Day, Year)

32. Begistrar's Signature

State Registrar

Division of Vital Records, P.O.

24 hours after death

To the Funeral Director:

State Registrar

DHMH 17 Rev 1/2001

OCMF 2006

3

Medical

Suicide

Homicide 29a. Certifier

29b. Signature and title of certifie

Zabiullah Ali, M.D. 31. Date filed (Month, Day, Year,

ADD

X Could not be

determined

and manner stated

Assistant Medical Examiner

known

and address of person who completed cause of death (Item 23a

other-scene

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c, License number

O.C.M.F.

111 Penn Street, Baltimore, MD 21201

or Town, State)

Owings mills, MD

29d. Date signed (Month, Day, Year)

April 22, 2009

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TTEM# 10eperFH, G890, 47,24709, WS
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 04 **Physician** Datri Cia Bruchman 2009 -5. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Catonsville Baltimore Manor Woodbridge Valle (Qunty Care If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral 1□M 200F 474-38-4290 Months Days Hours Director Usual Residence of Decedent 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evanting and Baltmore Wings mn 1 ☐ Yes 2 No Director mills 10e. Street and Number Groffs 10g. Citizen of What Country? 10f. Zip Code 8911 USA DR, OWINGS mill mill Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes, 2 ☐ No
If Yes, Give
Year or Dates:

1 ☐ Yes 2 ☐ No
Specify: permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiens. Important: If item 27 is marked other than "natural", or items; any injury or other traumatic event, Item Mental and Once. 14. Bace - American Indian 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 <u>Ş</u> Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Rosemood Hospital Nur Se 12th grade 17. Father's Name First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) tilden Enge .cretta 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Drive Owing Mill MD 21117 Bruchma 8911 Groffs Mill Bradley 20a. Method of Disposition 20e. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sykesville, MD akeview 21. Signatute of Funeral Service License C. Greene Tuneral SUCS Jamos andall stown MO21123 Load 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear tariure. List only one cause on each line. Immediate Cause (Final **Physician** 0 bs m LANC hronic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to for as a nonsequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician; The law requires that the death certificate be executed P.O. Box 68760, C. sician and burial-trans Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Obesita 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed page 2 should ARDIVASCULAR 24a. Was an autopsy performed? 1 □ Yes 2 ☒No 24b. Were autopsy findings available prior to completion of cause of death? has certificate 2 🗆 No 1 ☐ Yes 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 04-23-2009 DU059107 M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BUSINESS REISTERSTOWN 210 CENTER DRIVE 31. Date filed (Month, Day, Year) 32. Registrar's Signature APR 24 2009 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIEM#24a&26perVERB, G891,5720/09, WS
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) 15 PM **Physician** 2009 BYCZKOWSKI /Medical 4b. City, Town, or Location of Death County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Glen Carroll 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Day, Ye Days Min MD Yrs Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland . Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~-: any injury or other traumatic event. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 Yes 2 No W **Funeral Director** arroll 10g. Citizen of What Country? 10f. Zip Code 2115 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No Specify Specify: Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) tronic Technician years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Byczk 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type. Print) GWYNN Dak, MD Z1207 3486 Hil 'onstance iczkowski Date 20c. Location - City 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition Burial 2 Cremation 3 Removal from State -27-09 4 Donation 5 Dother (Specify) Ann C. Greene funeral sus 22. Name and Address of Fallity 21. Signature of Funeral Service License ndallstown, MD 21133 Approximate Interval Between Onset and Death Second 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as lardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Immediate Cause (Final nead **Physician** disease or condition resulting in death) NA MOT /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and s the burial-transit law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical use as attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 ☐Yes 2 ☐ No s been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Io the Hospital or Attending PhysIclan: 26. Place of Death (Check only one) funeral director, 25. Was case referred to medical Be examiner2 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specification) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this . Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending investigation 4/21/09 Found W:15M 1 □ Yes 2 🖃 🕶 in Nead Shot self death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 1 3 Solcide 28f. Location (Street and Number or Rural Route Number, City or Town, State)
699 Glen Drive Westminster MC 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide WESMINSTER MO 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 10 person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of Stev Rd Manchester 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 950 LOUIS BANASKIEWICZ 2 2 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FRANKLIN Square Hospital Center Baltimore Rosedale If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**X**XM 2□ F Days Hours Min. Director 213-18-0447 85 May 27,1923 Maryland Usual Residence of Decedent the Maryland 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notilled at 1 ☐ Yes 2 No Director Maryland Baltimore Baltimore County 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code with 15 Cliffwood Rd. 21206 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1√ X/es 2 □ No If Yes, Give Year or Dates: WW Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Itimore, Maryland 21215-0036 1 ☐ Yes 2XXNo White Specify. ₽ Specify: 3 X Widowed 4 ☐ Divorced WW 11 Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6 yrs. N/A Grinder Armco Steel Corp. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louis Banaskiewicz Stella Sobczynska ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 June Nemec (Stepdaughter) 4222 Mispillion Rd. Baltimore, Md. 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important: If ite any Injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Moreland Memorial Pk. 4-25-2009 Baltimore, Md. 4 Donation 5 Stother (Specify) Entonment 22. Name and Address of Facility
Lassahn Funeral Home
7401 Belair Rd. Baltimore, Md. 21236 Signature of Funeral Service/Ocensee Cotto 23a. Part 1. Enter the diseas or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final **Physician** SEPTIC Shock /Medical Due to (or as a consequence of): Examiner ACUTE ASperation PheumoniTis ACUTE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner been signed by the attending physician and should be detached for use as the burial-transi Due to (or as a consequence of) Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months?

1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Hypoxemic 1 ☐Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Respiratory Completed Acidosis 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No disease autopsy Division of Vital 2 1No LORONary ACTECY 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27, Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

anaski

3

0 31. Date filed (Month, Day, Year,

DR Martin

Sheridan 9000 FRANKLIN Square DR Balto md 21237 #32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

4-22-2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month II 20129 CHARLES ARTHUR BARRACLOUGH, Ph.D. Ø8:15A M 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Center 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Min. Months Days Hours 1 ₩ 2 □ F 156-18-3673 82 1926 July 13, New Jersey Usual Residence of Decedent 10b. County 10c, City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Baltimore County Towson 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21286 USA 704 Saylor Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 No If Yes, Give Y Year or Dates: 1 ☐ Never Married 2 💆 Married 1 □Yes 21 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) University of MD Elementary/Secondary (0-12) College (1-4or 5+) Medical School Professor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Romaine Charles Arthur Barraclough, Sr. Martha 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 704 Saylor Court, Towson, Maryland 21286 Eleanor Barraclough (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Green Mount Crematory 4/22/2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Science Martin D. Ławson 22 Name and Address of Facility MITCHELL-WIEDEFELD FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland <u>21212</u> 6500 Approximate Interval Between Onset and Death DAYS 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final SEPSIS disease or condition resulting in death) Due to (or as a consequence of): PERITONITIS DAYS 16 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): PERFORATED DIVERTICULUM OF SIGMOID COLON DAYS Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? MYOCARDIAL INFARCTION 1 ☐ Yes 2 Z No 3 ☐ Probably 4 ☐ Unknown CARCINOMA OF THE PROSTATE STAGE IV 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \(\subseteq\) Nursing Home \(5 \subseteq\) Residence \(6 \subseteq\) Other (Specify)

Physician /Medical Examiner

permit. Pages 1 and Department of Healt Important: If item 2 any Injury or other once.

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f sh traumatic event, the Medical Examinar must be notified

death with the Maryland

filed within 72 hours after

t and 2 should be the Health and Mental

OK for ME Baltimore, Maryland 21215-0036

burial-trar

Examiner

Physician/Medical

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Completed

Be

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Certification:

Medical

1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

the attending pl signed by the a

Hospital or Attending Physician: The law requires that the death certificate be executed $\mathcal{AU}_{\psi} \not\subset \mathcal{ME}$ Division of Vital Records, P.O. Box 68760,

certificate has been stirector, page 2 should s after dea... eral Director; A' rilled in by the 24 hours a Funeral I

within 2 To the 1

npletely

State Registrar

5 ☐ Pending investigation

6 Could not be

Date of Injury (Month, Day, Year)

and manner stated.

1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

29c. License number DØ17667

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year) 60

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (tem 23a) (Type, Print)

Hospital:

BOHORQUEZ, M. D. 7600 OSLER DRIVE TOWSON, MD RNANDO A.

31. Date filed (Month, Day, Year) 32. Pegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** APR 22, 2009 1:15 AM Rhiannon Bloom Melinda /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Montgomery Bethesda Bethesda Health

5. Social Security Number | 6. Sex & Rehab. Center Country, TN If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2√√□ F Months Days Hours 578-52-8530 Director FEB 10, 1940 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Modical Examiner must be mutified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 1 □Yes 2√□No Rockville Directo Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20850 904 Lincoln Street United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2XXNo If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1 □Yes 2XXNo Specify: ğ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Williams Lloyd Evan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Bloom/Son 14212 Arctic Ave., Rockville, MD 20853 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Chesapeake Crematory 4/23/09 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, MD 21. Signature of Fungral Service Licensee 22. Name and Address of Facility Rapp Funeral & Cremation Services 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 2001 0 p roximate Interval Between Onset and Death Immediate Cause (Final PNEUMONIA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner BRAIN DISTASÉ ETASTATIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed CHRONIC LYMPHOCYTIC attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) n signed by the a ☐Yes 2 No 9 Unknown 9 D Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ MASS 2 🗹 No 3 Probably 4 Unknown 1 ☐ Yes Completed CHRONIC OBSTRUCTIVE Luna 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 No After this certificate ANEWIA 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 🗹 Natural 5 Pending investigation 1 ☐ Yes 2 No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

Division of Vital Records, P.O. Box 68760, within 24 hours a

To the Funeral C D 17656 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5530 WISCONSIN AND #550 MD WOODWARD Registrar DHMH 17 Rev 1/2001 ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of M	arylan		artment of F rtificate of I		and Me		giene Reg. No. 🤈 🎧	100	13	N 2 3
	Physicia	an	1. Decedent's Name (First, Middle, La Reter	st) Blase	of ti					Date of Dea Month	Day	Year	3. Time o	Death M
	/Medic Examin		4a. Facility Name (If not institution, given				4b. City, Town, or	Location		pril	1	y of Death	01.31	\$F
-			University of Marylan				Bulhmore If Under 1 Year	If Under	24 Hrs. Lo.	Data of Dist		mart (
	Funeral Director		5. Social Security Number 6. 8 220-14-1727	Sex 7.Ag IDXM 2□F	9e (In yrs. I 82	ast birthday) Yrs.	Months Days	Hours	Min.	Date of Birth (Month, Day 13	, Year)	Cou	^{place (State} ntry) sylvan	
	ъ		Usual Residence of Decedent 10a, State 10b, County			v. Town or Lo	nation				,1,20		10d. Inside C	
	Maryla f shov led at	tor	Maryland Baltim	ore	Toc. City	, ,	sville							2 No
	h the l or 28a- e notif	Director	10e. Street and Number				10f. Zip Code				10g. Citizen of	What Cou	ntry?	
	23a c		1923 Westchester	Avenue			2122				US			
9036	I within 72 hours after death with the Maryland plene. I than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at the Medical Examiner must be notified at	d by Funeral	11. Marital Status 1 ☐ Never Married	12. Was Decedent Armed Forces? 1X Yes 2 ☐ If Yes, Give Year or Dates:	No	1	Was Decedent of H if Yes, specify Cuba 1 □ Yes 2 No	lispanic Ori an, Mexicar Specify:		fy Yes or No- can, etc.)	14. Ra Bla Speci	ace - Ameri ack, White, ify: Whi	etc	
Baltimore, Maryland 21215-0036	within 72 ho iene. • than "natu he Medical	Completed	15. Decedent's Eigenentary/Secondary (0-12)	ducation ade completed) College (1-4or	5+)	(Give life.	dent's Usual Occup kind of work done o DO NOT use retired	durina mos	t of working		16b. Kind of E			
d 2	Hyger Hyger		17. Father's Name (First, Middle, Last)		Ma1	ntenance	18. Mothe	er's Name (F	First, Middle,	Post Maiden Surna		e	
/lan	e d ta b	To Be	Samuel Blasetti					Anita	a Basi	1e				
/Jan	2 sho	'	19a. Informant's Name/Relationship				ng Address (Street						p Code)	
re, l	1 and 2 Health tem 27		Robert Paul Blase 20a. Method of Disposition	tti Son			Bellbeck position (Name of matory or other place)		; Balt		20c. Location		own, State	
E E	2 0 -		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci				matory or other place. Cemetery		4/27/0	9 E	Baltimo	re, M	larylar	nd
Balti	permit. Page Department Important: If any Injury or once.		21. Signature of Funeral Service Lice	se saud	heit	F 1	2. Name and Addre	ss of Facilit	y Ster f Cato	ling A	Ashton Le, Inc	Schwa	b Witz	zke
a.	Physician		Immediate Cause (Final disease or condition	one cause on each I	illo.			ng, such as brilla		espiratory an	rest,	ì	Approxima Interval Be Onset and	Death
۱	/Medical Examiner	r	resulting in death) Sequentially list conditions,	b. Due to (or es	section	14 au	tic anev	ysm					years-	
8760,00	cate be executed physician and the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as										
687	ificate physics the b	edical		d										
O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant 9 Unknown	2 Feta	Ideath 3	☐ Ectopic pregnand ☐ Other (specify) _	у				ate of deliv		Year
rds, P.	w requires that the d t been signed by the should be detached	þ	Part II. Other significent conditions	contributing to death I	out not resu	ulting in the u	nderlying cause giv	en in Part I		23e. Did to	obacco use cor 'es 2 No		the cause of	
Division of Vital Records,		Completed								24a. Was a autop perfor 1 □ Yes	SV	. Were autoprior to codeath? 1 □ Yes	opsy findings ompletion of 2 DXNo	available cause of
Vita	slcian: The scertificate lirector, pag	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	iont 2 🗆	EP/Outnatia	nt 3 □ DOA Oth	or:		Check only or	ne) dence 6 ⊡O	thor (Case	:4.1	
ion of	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	ation: To	27. Manner of Death 1 □ Natural 5 □ Pending 2 □ Accident investigation	28a. Date of inj (Month, Da	ury	28b. Time of Injury	of 28c. Injui Wor		280		now injury occu	1-1	<u> </u>	
Divis	tal or Atte s after dea al Director ed in by th	Certification:	3 ☐ Suicide 6 ☐ Could not to determined	28e. Place of In	jury - At ho tc. <i>(Sp</i> ec <i>if</i>	ome, farm, st	reet, factory, office	-	28f	f. Location (S City or Tow	Street and Num vn, State)	nber or Rui	ral Route Nur	mber,
	he Hospital	edical		hysician: To the best miner: On the basis and manner s	of examina									s)
	To the l within 2 To the l complet	Ž	29b. Signature and title of certifler				29c. Licens		352/		29d. Date sign	ed (Month)		
	i0		30. Name and address of person who				Print)				April 2			
	Sta Registr		31. Date filed (Month, Day, Year) APR 242)09 Sarev	rar's Signa	ture 4	arkel							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#18perFH, G890, 4/29709, WS State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 0405AM 23 pri 2009 Lydia 0 Brown /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital 01nev Montgomery 8. Date of Birth October 1930 Pennsylvania 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex **Funeral** Hours Months Days 1 □ M 2 □ F 78 579-38-2039 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State d 2 should be filed within 72 hours after death with the Marylan thit and Mental Hygiene. 27 Is marked other than "natural", or items 23a or 28a-f show traumaite event, The Medical Extraince must be notified at Highland 1 ☐ Yes 2 ☐ No Howard Maryland Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20777 6725 Montell Court Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: δ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Domestic Dermit. Pages 1 and 2 should be file.
Department of Health and Mental Hya.
Important: If them 27 Is marked any injury or other to once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Antonette Mastrangell Mastrangelo Vincent Louis Vinella 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Columbia, MD 21045 Douglas J. Brown/son 9744 Basket Ring 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation Service Inc. 4/24/09 Sykesville, MD Haight Funeral Home & Chapel, P.A. P.O. Box 195 Sykesville, MD 21784 (410-795-1400) 21. Signature of Funeral Service Licenses Drung Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 6 month Metartetiz Concer /Medical Due to (or as a consequence of): Examiner Local / Pegional
Due to (or as a consequence of): Lett 2 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine signed by the attending physician and be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 🔲 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown certificate has been si rector, page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certification completely filled in by the funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural
2 Accident (Month, Day, Year) Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number MO MD 060335 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Prince Philip 女 327 Olney, MD 20832 Drive Banner MD 31. Date filed (Month, Day, Year) State APR 24 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#8perINF, G891, 574, 09, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month 18, Doris J. Brown <u>April</u> 2009 12:07 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Bel air Harford If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 1920 Feb 18, 19120 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 🔽 F 217-09-5675 89 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ortant: If item 27 is marked other than "natural"; or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at Director MD Harford Fallston 1 ☐ Yes 2 ▼ No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code m9F021007 3515 Fallston Road 21047 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status a filed within 72 hours after dail Hygiene. Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: white 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) <u>housewife</u> is marked other own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be should be f and Mental I Howard Leroy Claytor ၉ Annie Pearl Wise 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 Pages 1 and 2 tment of Health a Ronald Blum/son 3515 Fallston Road Fallston, MD permit. Pages 1 and Department of Healt Important: If item 2 any injury or other once. 21047 ltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Signature of Financial Mic Sicens de State Anatomy Board 655 W. Baltimore Street Bal Director Baltimore, MD 21201 23a. Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Chuse (Final disease or condition resulting in death) Physician Intru Cerebul /Medical Due to (or as a consequence of): Examiner roccuteb Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Hypertensin Due to (or as Jonsequence of): the attending physician and the doruge as the burial-tran P.O. Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 20 No 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy certificate 2 2 N 1□ Yes Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 20 No Certification: To To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Natural 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) DOO 36487 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mo 500 upper one sapeake Drive Bel Air, MO 21014 Steven Bentman

State

Registrar

31. Date filed (Month, Day, Year)

APR 24 2009

2. Registrar's Sign ture

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death **Physician** 6,2000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death The Hebrew Home Rockville Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Dec 2, 191 Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□F Days Hours 97 Director 278-12-2891 1911 Austria Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery 1 ☐ Yes 2 ☑ No Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6105 Montrose Road Completed by Funeral 20852 USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No 3 Widowed 4 □ Divorced Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) musician entertainment 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nathan Blatt Eva pachman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Blatt/son 13004 Blue Valley Place Silver Springs, MD 2 of Disposition (Name of Date 20c. Location - City or Town, State 20904 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Othe (Specify) 21. Signatur of Funeral ervice Licensee Konald S/W 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Conse (Final disease or condition resulting in death)

a.

Due to for as a consequence of the condition of the consequence of the condition resulting in death) **Physician** /Medical ARTERY DISEASE Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician; The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy 25. Was case referred to medical examiner? 26. Place of Death (Check only one) ဥ 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: 28c. Injury at Work? 1 L Natural
2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) in by t 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospitai Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and the of certifier alleni ITEDIERD ROCKVILLE, MD ZOSSE

State Registrar 31. Date filed (Month, Day, Year) APR 2 4 2

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1- FoAmend Items 25,26 ater of Maryland / Deportment 24/09all	hand Mental Hy th	ygiene Reg. No. 2009	13087
Physici	an.	1. Decedent's Name (First, Middle, Last)	2. Date of D	eath Year	3. Time of Death
/Medic		HENRY BENDER	Marc	h 28 200	9 17:00 M
Examin	ier	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location		4c. County of Dea	
		Northwest Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 1 Year	nder 24 Hrs. 8. Date of B		rthplace (State or Foreign
Funeral Director		213-76-1812 17 M 2 F 59 Yrs. Months Days Hou	urs Min. (Month, I	Day, Year) C	ountry) unk
		Usual Residence of Decedent	puly 2	, 1949	
rylan	_	10a. State 10b. County 10c. City, Town or Location Baltimore Baltimore			10d. Inside City Limits
Ba-f s	Director	Baltimore Baltimore			1 □Yes 2 No
with the Maryland a or 28a-f show be notified at	Dir	106. Street and Number 6001 Loch Raven Blvd		10g. Citizen of What C	ountry?
sath w	Funeral	21225		USA lo- 14. Race - Am	erican Indian
ter de	Fun	11. Marital Status unk 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic 1	xican, Puerto Rican, etc.)	Black, Whi	
urs aft	þ	If Yes, Give 1 ☐ Yes 2X No Spect Year or Dates:	cify:	Specify: W	nite
72 ho	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during r.	mast of working unk	16b. Kind of Business	s/industry unk
J within 7 giene. r than "n	ď	Elementary/Secondary (0-12) College (1-4or 5+) life, DO NOT use retired)			
ified within 72 hours after death with the Maryland filed within 72 hours after death with the Maryland Hygiene. Other than "natural", or items 23a or 28a-f show ent, the Medical Evaning rust be notified at		unk unk 17. Father's Name (First, Middle, Last) unk 18. Mi	Nother's Name (First, Middle	e Maiden Surname)	
d be fental l	Be c	Tr. Father's Natine (1735, Wildows, East)	iother's Name (First, Micon	e, maiden Gurriame)	unk
is 1 and 2 should be filed within the Health and Mental Hygiene. The Tay is marked other than other traumatic event, Italy	ျှ	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Nu	umber or Rural Route Num	ber. City or Town. State.	Zip Code)
and 2 sealth an n 27 is	١.,	Northwest Hospital 5401 Old Court Ro			1.2.2
s t all strengther str		20a. Method of Disposition (Name of cametery crametory or other place)	Date Date	20c. Location - City o	Town, State
Page nent o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) in / State			
permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra		21. Signature of Funeral Service Licensee	acility	1	
8 3 2 2 8		Ronald 3. Water Director State Anatomy Baltimore, MD	Board 655 W	. Baltimore	Street
		a. Part . Enter the dise lie, or complications that caused the death. Do not enter the mode of dying, such shock or heart failur. List only one cause on each line.	h as cardiac or respiratory	arrest,	Approximate Interval Between
Physician		Immediate thise (Final disease or condition resulting in death) a. RESULGIVY Failv6			Onset and Death
/Medical Examiner		ue to (ir as a consequence of):	D.	0	
	in line	Sequentially list conditions, if any leading to immediate b. End Stage Chronic Chronic Indiana Due to (or as a configuence of):	ichve filmo	nary Disea	6
uted d Insit	Examiner	cause. Enter Underlying Cause (Disease or injury		11.5	
be executed sician and burial-transit	Exa	that initiated events c			
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	Med	IF FEMALE:			
eath certific attending p	jan/l	23b. Was decedent pregnant in the past 12 months?		23d. Date of d	elivery Day Year
e de de	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 5 ☐ Other (specify)			
res that the signed by be detac		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pa	Part I. 23e. Did	I tobacco use contribute	to the cause of death?
uires n sigr	d by		1	Yes 2□No 3□I	Probably 4 🔲 Unknown
w requir s been s should	lete		24a. Wa	s an 24b. Were a	autopsy findings available
The lav	ompleted		per	formed? death?	
	S S	25. Was case referred to medical 26. P	1 □Yes		5 2 140
di is	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4	☐ Nursing Home 5 ☐ Re	sidence 6 Other (Sp	Seasons Pecify) Hospice
ine ine		28a. Date of Injury 28b. Time of 28c. Injury at 1 Natural 5 Pending (Month, Day, Year) 28b. Time of Injury Work?	28d. Describe	e how injury occurred	
Attending r death. ector; After by the fune	cati	2 Accident investigation M 1 Yes 2			
pital or Atten ours after deat eral Director: filled in by the	Certification:	3 Suicide 4 Homlcide 4 Homlcide 4 See. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location City or T	(Street and Number or I own, State)	Rural Houte Number,
spital ours neral filled		29a. Certifier 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, dat	ite and place, and due to the	ne cause(s) and manner	as stated.
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	ledical	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, and manner stated.	, death occurred at the tim	e, date and place, and di	ue to the cause(s)
To th withir To th	ĕ	29b. Signature and title of certifier 29c. License numb	ber	29d. Date signed (Mor	nth, Day, Year)
		Mellah Dentin H4593		AHRILI	2009
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Descrah Surtan 2835 Smith Ave Suite:	203 Baltin	nore MD	21209
Sta Regist		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Deborah Burton 2835 5m th Ave Suite 31. Date filed (Month, Day, Year) APR 24 2009 Registrar's Signapire April 1998			
	_				

DHMH 17 Rev 1/2001

State Registrar

APR 24 2000

2009

BECZKOWSKI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 8:45 AM FRANCES COWPER MARY ORi 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner LANHAM PRINCE GEORGE'S DOCTOR'S HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, JULY 29 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year Days 1 □ M 2 □ XF ANDERSON, S.C. 1932 243-52-6904 76 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location 28a-f show event, the Medical Examiner must be notified at 1 X Yes 2 □ No Director PRINCE GEORGE'S MD LANHAM 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number , or items 23a or 20706 USA 5502 ELMIRA AVENUE Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 X No Specify: BLACK Specify. ģ 3 Widowed 4 Divorced "natural" Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the I'm any injury or other traumatic event, the I'm one. Elementary/Secondary (0-12) College (1-4or 5+) REGISTER GOVERNMENT NURSE 4+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be WILLIAMS **BERTHA** CAMPBELL ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) CALVIN S. COWPER/HUSBAND 5502 ELMIRA AVENUE LANHAM, MARYLAND 20706 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State MD VETERANS CEMETERY 4/27/2009 CHELTENHAM, MARYLAND 4 □ Donation 5 □ Other (Specify) 21. Signature Punaral Sarvice Censee J. B. JENKINS FUNERAL HOME 22. Name and Address of Facility 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. shock, or heart failure. List only Immediate Cause (Final **Physician** ANCREATIC TASTATIC ME disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) attending physician for use as the burial Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 5 ☐ Other (specify) 1 ☐Yes 2 🗷 No detached 9 Unknown signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 ☐ Yes 2 No 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation in 24 hours after death.
The Funeral Director: Af 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 🗌 Homicide

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State Registrar

Medical

31. Date filed (Month, Day, Year) APR 24 2009

Shears

29a, Certifier

(Check only one)

ROAD

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #103, LANHAM, MD 20706

and manner stated

Hamm, MD

32. Registrar's Signature

within 2 To the I

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

050862

29d. Date signed (Month, Day, Year)

SHERIF HASSAN, MD. 983/ GREENBELT

APRIL, 16, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🚄 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month Day **Physician** JEAN SHIRLEY COHO 1001 GM 2009 /Medical 4a. Facility Name (If not institution, give street, and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Catonsville Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Sept 29a, 1928 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M XX F 195-22-5756 80 Pennsylvania Yrs Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ir than "natural", or items 23a or 28a-f show the Medical Examiner must be nutilled at 1 ☐ Yes XX No Director Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 912 South Rolling Road #205 21228 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 □ Yes 2XXVo Specify: White \$ XX Widowed 4 □ Divorced Specify: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, the Mones. College (1-4or 5+) Paralegal Law 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Carl Linden Hazel Kerr ပ္ 19a. Informant's Name/Relationship (Type. Print) Judy Coho 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DTR 7 Forest Drive Catonsville Maryland 21228 Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 (A) cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State GreenMount Crematory April 24,2009 Baltimore, Maryland ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility John O Mitchell IV Funeral Services of ignature of Funeral S Dulaney Valley 200 East Padonia Road Timonium Maryland 21093 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 1 day /Medical Due to (or see onsequence of): Examiner num on Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): 68760 physician Physician/Medical the attending p Box IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🎗 No Month Day Year 5 ☐ Other (specify) signed by the a P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 2 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate 1 □ Yes 2 No 1 TYes 2 Mo Division of Vital this certific al director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After thi 28b. Time of Injury 27. Manner of Death Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of dertifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Calveston St Ratosvi 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) April 22, 2009 2:50 P.M Colvin Susan 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Baltimore Parkville 3106 Woodring Avenue If Under 1 Year If Under 24 Hrs. 8. Date of Birth April 6, 1947 9. Birthplace (State or Foreign 6 Sex Age (In yrs. last birthday) 5. Social Security Nu 212-46-8770 Min. Maryland Months Days Hours 62 1 □ M 2 □ X F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Parkville Baltimore 1 ☐Yes 2 No Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21234 3106 Woodring Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11. Marital Status 1 ☐ Never Married 2 ☐ Married Specify: White 1 □Yes 2 XNo If Yes, Give Year or Dates: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Department Store Sales Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Roberta Mungin John Cook 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3614 Heathers Way Parkville, Maryland 21234 Robert Smolinski/Brother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 4/24/09 Towson Maryland 21. Signature of Funeral Service Licensee ^{22. Name and Address of Facility Tenanya J. Ruck 5305 Harford Road Baltimore Maryland 21214} 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month 5 ☐ Other (specify) 23e Did tobacco use contribute to the cause of death? iditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 🚧 No 3 Probably 4 ☐ Unknown

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

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Funeral

Director

The marked other than "natural", or items 23a or 28a-f show traumatic event, the "Modical Exminiter mast to notified at

permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene, important: If item 27 is marked other than "ne any injury or other traumatic never

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

Examiner Physician/Medical

as the burial-tran and cate has been signed by the attending physician page 2 should be detached for use as the buria 2 Completed certificate Hospital or Attending Physician: 1
 24 hours after death.
 Funeral Director: After this certifica filled in by the funeral director, Be Certification: To

The law requires that the death certificate be executed

Box 68760,

P.O.

Division of Vital Records,

	d
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ₩2Unknown	23c.

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an

26. Place of Death (Check only one, Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work?

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2

4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

autopsy perform

1∏Yes

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

25. Was case referred to medical examiner?

1 Tes

27. Manner of Death

2 ☐ Accident

4 ☐ Homicide

3 ☐ Suicide

29a. Certifier

Medical

State

2 200

5 ☐ Pending investigation

6 ☐ Could not be

determined

🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 ☐ Yes 2 ☐ No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 60116'e6 7504 ms

31. Date filed (Month, Day, Year)

32. Registrar's Signature

within 24 hor To the Fune completely f 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 12:55 P.M 2009 April Lessie Stallard Collins /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Lochearn

Todar 1 Year | If Under 24 Hrs. <u>Baltimore</u> Augsburg Lutheran Home Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours Months 1 □ M 2 1 1 F 30,1909 Virginia 99 Nov. 540-26-6375 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it is Medical Examinar must be notified at 1 ☐ Yes 2 No Director Baltimore Maryland Baltimore the 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number death with 21208 USA 200 Glenn Ellen Circle Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒ No IfYes, Give Year or Dates: Race - American Indian, Black, White, etc. 11 Marital Status 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🏻 No Specify: White Saltimore, Maryland 21215-0036 Specify à 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within 7 Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker R 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 12 should be fill the and Mental H Be Robert Eli Edwards Laura Meade 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is rr any injury or other traum once. 200 Glenn Ellen Circle; Baltimore, MD 21208 Sister Virginia Ensenat 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4-24-2009 Pound, Virginia Crouse Cemetery 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Funeral Home of Catonsville, MD 21228 Witzke 21. Signature of Funeral 89 21228 1630 Edmondson Avenue; Catonsville, MD 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final disease or condition resulting in death) 10 Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and burial-tran Due to (or as a consequence of): physician Physician/Medical the use as IF FEMALE 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day for in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 No cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2. No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 2 🗌 No certificate 1 ☐ Yes 1 ☐ Yes director.

the Hospital or Attending Physician; The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, this After vithin 24 hours after death.

• the Funeral Director: A

ompletely filled in by the fu within 24

To the F

complete

26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1∐ Yes 2—∠No Certification: To 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death Injury 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 □ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one)

29c. License number

37.

Reisterstown

29d. Date signed (Month, Day, Year)

2009

21136

State Registrar

funeral

11adis MD Year) 31. Date filed (Month, Day,

29b. Signature and title of certifier

30. Name and address of person who completed

Manis 32. Remistrar's Signature parke

ause of death (Item 23a) (Type, Print)

09-02408

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	State of Maryland /	Department of He	salth and Monte	al Hygiene
	State of Maryland /	- Бераппения пе	tailli and Meni	al Hydrelle

ouis Frank Claes	1-	State of Maryland / Depa For State Cer	artment of rtificate of			Reg. No.	200	0 1300
Physician		edistrar Decedent's Name (First, Middle,Last)			2. Date of De	ath	Year	3. Time of Death
Medical Examine		Louis Frank Claes		b. City, Town, or Location of	Month March 28		nty of Death	2059 hrs
	B	a. Facility Name (if not institution, give street and number) 1004 Philadelphia Avenue		Ocean City		Word	ester	halana (Chata an
Funeral Director	L	. Social Security Number unk $ \begin{array}{c ccccccccccccccccccccccccccccccccccc$	last birthday) Yrs.	Months Days Hours	Min.	0, 194	Foreig	hplace (State or n J ^{intry} Maryland
any	_	Isual Residence of Decedent Oa. State 10b. County 10c. City,	, Town or Location	on				10d. Inside City Limits
A .tl	اي	MD Worcester	0cean	City				1 Yes 2 X No
Maryland 28a-f show d at once.	Director	0e. Street and Number		10f. Zip Code		10g. Citizen o	of What Cour	ntry?
3a or		1004 Philadelphia Avenue #6		21842		USA		District Block
eath with the Maryland items 23a or 28a-f sho	Funeral	1. Marital Status Never Married 2 Married Armed Forces?	If Yo	s Decedent of Hispanic Ori es, specify Cuban, Mexican	gin? (Specify Yes or f , Puerto Rican, etc.)	NO- 14. F	Nhite, etc.	can Indian, Black,
		1 Y Yes 2 No Widowed 4 X Divorced If Yes, Give Yeer vietna:	m 1	Yes 2 X No specify.		Spec	cify:	white
ours af	<u>8</u>	15. Decedent's Education (Specify only highest grade completed)	16a. Deceden	t's Usual Occupation (Give ost of working life. DO NOT	kind of work done	16b. Kind	of Business/I	ndustry
21215-0036 uld be filed within 72 hours after death with the Maryland Mental Hygiene. marked other than "natural", or items 23a or 28a-f she event, the Medical Examiner must he notified at one	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 12		penter	,	self	emp1	oyed
5-00 ed with tygien of ther	ᇹ	7. Father's Name (First, Middle, Last)	1	18.Mothe	r's Name (First, Middle			unk
21215-0036 and be filed within 7 Mental Hygiene. warked other than e event, the Medica	å	Frank George Claes	405 14-15-			lumbar City or	Town State	Zin Code)
MD 21 d 2 should th and Me n 27 is ma aumatic ev	٩	9a. Informant's Name/Relationship (Type, Print)	T	Address (Street and Nur				- 1
and and lealth lien iren	ŀ		Place of Dispos crematory or oth	Rain Willow I sition (Name of cemetery,	anw Dulut	20c. Local	illin Eily or	Town, State
mor Pages 1 ent of 1 nt: If		1 Burial 2 Cremation 3 Removal from State 4 Dongtion 5 X Other Specify: in State	crematory or on	nei piace)				
Baltimore, permit. Pages 1 a Department of He Important: If ite injury or other tr	- 1	21. Signature of Francis Service Licensee Name , inector	Ba1	Name and Address of Facili The Anatomy I Timore, MD	21201			Street
Physician		3a. Part I Enter the disease, or complications that caused the death failure List only one cause on each line.	h. Do not enter t	he mode of dying, such as	cardiac or respiratory	arrest, shock,	or heart	Approximate Interval Between Onset and
/Medical xaminer		Immediate Cause (Final disease a. Atherosclerotic Cardio		ease				Death
		h	or):					
	<u>le</u>	Sequentially list conditions, if any, leading to immediate Cause. Enter Underlying Cause	of):					
	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence	of):				<u>. </u>	
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o,0, e be ex ysician burial	ledical	UNPENDED AMENDED	an an au			23d D	ate of deliver	
876 tificate ng phy as the	<u>≅</u>	F FEMALE: 3b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pre		etal death 3 Ector	ic pregnancy	Mo		Day Year
Box 68760, e death certificate be the attending physic ed for use as the bur	Physician/M	Yes 2 No 9 Unknown 4 Pregnant at time of d	death 5 O	ther (Specify)		ì		j
J. B.	ᇍ	Part II. Other significant conditions contributing to death but not	resulting in the	underlying cause given in F	Part I. 23e. Di	d tobacco use	contribute to	the cause of death?
P.O.	a p					Yes 2 N	o 3 Pro	bably 4 🗸 Unknown
rds v requi	Completed					utopsy	prior to	utopsy findings available completion of cause of
Recc The lav	E I					erformed? es 2 No	death? 1 ✔ Y	res 2 No
tal Risian: 1	Bec	25. Was case referred to medical examiner? [Hospital: 4 Inpution: 2]		IOther:	h (Check only one)	5	0.404	
Division of Vital Records, In or Attending Physician: The law requirers after death. The Director: After this certificate has been side in by the funeral director, page 2 should be in by the funeral director, page 2 should be in the funeral director.	힏	1 Ves 2 No Prospital 1 Inpatient 2 27. Manner of Death 28a. Date of Injury	ER/Outpatien	1 3 DOA 4	Nursing Home 5 rk? 28d. Descri	be how injury	c 6 🗸 Othe	er: Scene
nding th r: Aft	اق	1 ✓ Natural 5 Pending (Month, Day, Year)		1 Yes 2				
/iSic	fical	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At	home, farm, stre	eet, factory, office building,		on (Street and	Number or R	ural Route Number, City
Djy pital o ours af neral D	Certification:	4 Homicide determined (Specify)						
Division of Vital Records, P.O. Box 68760, within 24 hours after death To the Inspiral or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial are page 2.	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowle (Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	dge, death occu and/or investiga	urred at the time, date and pation, in my opinion, death o	place, and due to the opecurred at the time, d	cause(s) and mate and place,	anner as sta and due to t	ited. he cause(s)
- F. 18 F. 8	Be	29b. Signature and title of certifier		29c. License numbe	er			onth, Day, Year)
		Dan Maria		O.C.M.E.		iviarch	27, 2009	
		30. Name and address of person who completed cause of death (Ite Donna M. Vincenti, MD Assistant Medical Exa	aminer 11	1 Penn Street, Baltir	more, MD 21201			
Sta Regist	ate rar	31. Date filed (Month, Day, Year) APR 2 4 2009 APR 2 4 2009	de for	Kel				
-109101	إبند	The state of the s						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death Day 2009 April 21, Louis Anthony Cornet 10:39 P M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery | Trunder 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours | Min. | February 8, 1926 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 🔀 M 2 🗆 F 83 Washington, D.C. 578-46-0873 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1⊠Yes 2□No Maryland Montgomery Rockville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20850 2405 Glenmore Terrace United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊟Yes 2 □ No If Yes, Give Year or Dates: WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Raca - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married Specify: White 1 ☐ Yes 2 ☑ No Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Labor Relations Advisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dr. Louis A. Cornet Mary Hurley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Ann Cornet/ Wife 2405 Glenmore Terrace, Rockville, Maryland 20850 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven
Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Date 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State April 27, Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Address of Facility Robert A. Tumphrey Funeral Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850 Tumphrey Funeral Home/ 21. Signature of Funeral Service Licensi Rockville, M01498 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocardial Infarction minutes Due to (or as a consequence of): 4 days Pulmonary Embolus Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dut to for as a consequence off Metastic Cancer weeks Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contributa to the causa of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Chronic Obstructive Pulmonary Disease autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Prostate Cancer 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred

Physician/Medical

Examine

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Completed

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Certification: To

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Physician

/Medical

Examiner

Director

Funeral

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any hjury or other traumatic event, the Medical Examinat must be retiffed at once.

Physician

/Medical

Examiner

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completely 1

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

27. Manner of Death

1 X Natural 5 Panding investigation 2 Accident 6 □ Could not be 3 Suicida determined

4 - Homicide

29a. Certifier

28a. Date of Injury (Month, Day, Year) 28b. Time of

28c. Injury at Work?

1 ☐ Yes 2 ☐ No Place of Injury - At home, farm, streat, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifie

29c. License number D35792

1 🔯 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) April 22, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kevin M. Gill, M.D. 14816 Physicians Lane #253 Rockville, Maryland 20850

State Registrar 31. Date filed (Month, Day, Year) APR 24



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Whei Chung Chang 10:57 A M April 17 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 501 Hungerford Drive #143 Rockville Montgomery 8. Date of Birth (Month, Day, Y If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Securify Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year. Days Hours Min. 1 X M 2 □ F 056-50-0102 67 1941 Japan Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f sho 1 X Yes 2 □ No Directo Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 501 Hungerford Drive #143 20850 United States by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐Yes 2X No Specify: Specify: Asian 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Medicine Physician/Anesthesiologist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Tung Fun Chang Sang Hua Kao မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 501 Hungerford Drive #143, Rockville, Maryland 20850 June Chang / Wife or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H Important: If ite any Injury or ot once. April 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery: 4 ☐ Donation 5 ☐ Other (Specify) 2009 Silver Spring, Maryland 21. Signature of Funeral Service Licens e 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. M01546 300 West Montgomery Avenue, Rockville, Maryland 20850 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 1 Hour Acute Myocardial Infarction Due to (or as a consequence of): Hypertensive Cardiovascular Disease Many Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hyperlipidemia Many Years Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 Quadriplegia due to Machado-Joseph Disease, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed Benign Prostatic Hypertrophy with Obstructive Uropathy 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an 1 ☐ Yes 2 🕅 No 25. Was case referred to medical

Physician /Medical Examiner

28a-f show

hours after death

within 72

Pages 1 and 2 should be filed vent of Health and Mental Hyginant: If item 27 is marked other

Baltimore, Maryland 21215-0036

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burial-transi aftending physician for use as the buria ed by the a detached f signed to has director, funeral After 1

Division of Vital Records, P.O. Box 68760

Be Certification: To To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Af

-1	examiner?					20.	I lace of Dea	tur (Check Chiy She)
	examiner/ 1∭ Yes 2 □ No	o	Hospital: 1 ☐ Inpatient	t 2 ER/Outpatient	3 🗆 [DOA Other: 4	I ☐ Nursing H	lome 5 X Residence 6 ☐ Other (Specify)
	2 Accident	5 Pending investigation			М	28c. Injury at Work? 1 ☐ Yes	2 □No	28d. Describe how injury occurred
	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	e 28e. Place of Injury building, etc.	y - At home, farm, stre (Specify)	et, facto	ory, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

i 🗓 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number D26707

29d. Date signed (Month, Day, Year) April 17, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tung-Pi Lee, M.D., 700 Buckingham Drive, Silver Spring, Maryland 20901 31. Date filed (Month, Day, Year) APR 2 4 2009

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year LEONARD J. CIOTTA, SR. 12:50 P APRIL 21, 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death TOWSON or 1 Year | If Under 24 Hrs. MANOR CARE - RUXTON BALTIMORE If Under 1 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace Country) (State or Foreign Days 1**X**□ M 2□ F Months Min Yrs 88 2/15/1921 219-03-0778 MARYLAND Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No MD BALTIMORE PARKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8102 RIDGELY OAK ROAD 21234 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: 3 Widowed 4 □ Divorced Year or Dates: WWII WHITE 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) TIME KEEPER SHIPPING COMPANY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) SALVATORE CIOTTA JOSEPHINE CARUSO 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LEONARD CIOTTA, JR./SON 128 AYLESBURY ROAD TIMONIUM. MD 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State DULANEY VALLEY MEM. 4 ☐ Donation 5 ☐ Other (Specity) 4/24/2009 COCKEYSVILLE, GARDENS 4/24/2009 CARDENS OF Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee MOO2 17 21286 8521 LOCH RAVEN BLVD. TOWSON. MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approxi*m*ate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) coronas year Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🗌 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 HNO 2 1 No 1 ☐ Yes 1 ☐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation

and burialphysician the burial attending p use as signed by the a d be detached f o the þ σ. Division of Vital Records, peen has page 2 certificate this funeral After 1 or Attending within 24 hours aries come to the Funeral Director: Aff To the Hospital

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Certification: To

Medical

29b. Signature and title of certifier

Funeral

Director

marked other than "natural", or items 23a or 28a-f show umatic event, the Muslical Extra direct mast be profiled at

72 hours after

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Pages 1

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Physician

/Medical

Examiner

Maryland 21215-0036

Baltimore,

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 ☐ Yes 27. Manner of Death 1 Natural 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated

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State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 02 York 0 1 0 0 31. Date filed (Month, Day, Year)

32. Registrar's Signature

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DHMH 17 Rev 1/2001

29d. Date signed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10b&17; tate of Maryland 7 Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 🤈 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** $04^{-18} - 2009$ 510 A Elisa R. DeLeon /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 2602 Hess Rd Fallston Harford If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month Day Year) 03-25-1927 Birthplace (State or Foreign Country)
 CA 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 ☐ M 2 🕏 F 466-22-2310 82 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It. Wedical Exactional to confidence. _{Behar} Bexar San Antonio 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1142 West Thompson P1 78226 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [X]No 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 X Yes 2 No Specify. ⋛ 3 ☐ Widowed 4 ី Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Food Company Quality Control Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name *(First, Middle, Last)* **Pablo Pauble** DeLaRosa Be Delfina Samaniego ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2602 Hess Rd Fallston, MD 21047 Diana D. Eustace (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Sunset Memorial Park | 4-24-2009 San Antonio, Texas 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Schimunek Funeral Rome 21. Signature of Funeral Service Licensee 9705 Belair Rd. Nottingham, Md. 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Burdes Julmon disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner DSCVI Sequentially list conditions, if any, leading to immediate cause. Clases (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner lor Attending Physiclan: The law requires that the death entificate be executed attending physician and for une as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Dypothy Co. D 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed FRENCE ENT 61 BlERDING 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy certificate 1 ☐Yes 2 No filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Daughter's Pesidence Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 24 hours after death. e Funeral Director: After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) within 2 and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 120 2000 D32217 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/200

State Registrar Dru, D 5

31. Date filed (Month, Day, Year)

Lisw, mr. Sha.

32. Registrar's Signature

09-03187 Matthew Dietz

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

latthew Dietz	State of Maryland / Department of Hea		ygiene Reg. No	200	19 13098	
Physician/ Medical Examine	1. Decedent's Name (First, Middle,Last)		2. Date of Death Month Day April 20, 2009	Year	3. Time of Death 2329 hrs	
	4a. Facility Name (if not institution, give street and number) 4b. City, Upper Chesapeake Medical Center Bel	Town, or Location of Death	4	4c. County of Deat Harford	h	
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Un Mon 214-72-7318 15. Mon 2 F 36 Yrs.	der 1 Year If Under 24Hrs. ths Days Hours Min.	_ `	Forei		
und show any ite,	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland Harford Edgewood				10d. Inside City Limits 1 Yes 2 XXNo	
with the Maryland us 23a or 28a-f show be notified at once. aral Director		ip Code 21040	10g. C Un O:	oc. Citizen of What Country? United States of America		
r death	1 3 Widowod 4 Divorced III Yes Give Year 1 1 Yes	dent of Hispanic Origin? (Sp cify Cuban, Mexican, Puerto 2XX No specify:		14. Race - Ame White, etc.	rican Indian, Black, White	
5-0036 led within 72 hours after bygiene. other than "natural", the Medical Examiner. Completed by 1	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usua	al Occupation (Give kind of working life. DO NOT use retire		Kind of Business		
De fill be fill rinked ent,	Lingard Frederick Dietz, Jr.	Canda	(First, Middle, Maide .ce Sara W	ray		
MD 21 d 2 should th and Me n 27 is ms aumatic e	Mr. Lingard F. Dietz, Jr./ 1927 Sc	ss (Street and Number or F outhridge Dri	ve Edgew	ood, Mar	yland 21040	
Baltimore, MD 2's permit. Pages 1 and 2 should Department of Health and MI Important: If item 27 is me injury or other traumatic error	20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (N Evans Function of the place of the place of Disposition (N Evans Function of the place of the	f Chapel- Apr 2	ril 23, 2009 F		ll, Maryland	
	21. Signature of Funeral Service Licensee 22. Name at Peacle: 23. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mod	25 York Road	Timonium	, Marylai	ation Ctr.,P.A. nd 21093 Approximate Interval	
Physician /Medical xaminer	failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,				Between Onset and	
ransit Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):					
60, at the executed hysician and e burial - transit	X UNPENDED AMENDED 23a,27,28a-f per IF FEMALE: 23c. If yes, outcome of pregnancy	me g892 6-11-		23d. Date of delive	ry	
b. Box 68760, the death certificate be executed the attending physician any ched for use as the burial - tri	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 2 Fetal deal 5 Other (S)			Month Month	Day Year	
P.C es that es that igned I be deta	à	ng cause given in Part I.	23e. Did tobacc		o the cause of death?	
of Vital Records, P.O. Box 6876 ge Physician: The law requires that the death certifica ther this certificate has been signed by the attending pheneral director, page 2 should be detached for use as the series of the Commission of the Physician Manner of the physician M	O D D D D D D D D D D D D D D D D D D D		24a. Was an autopsy performed	prior to		
Vital Recysician: The his certificate director, page	25. Was case referred to medical examiner?	26.Place of Death (Check		idence 6 Oth	er:	
ion of Vital F tending Physician: eath. for: After this certifi the funeral director,	27 Manner of Death 28a Date of Injury 28h Time of Injury	28c. Injury at Work? 1 Yes 2 X No	28d. Describe how i			
ivis or At after d Direct I in by	Natural Natural Accident Suicide Homicide Natural Suicide Accould not be determined Natural Suicide Accident Suicide Accould not be determined Could not be determined Could not be determined Natural Suicide Could not be determined Could not be determined Could not be determined Natural Suicide Could not be determined Could not be determined Natural Suicide Could not be determined Natural Natural Suicide Could not be determined Natural Could not be determined Natural Suicide Could not be determined Natural Could not be determined Natural Could not be determined	ry, office building, etc.	28f. Location (Stree or Town, State) Edgewood		Rural Route Number, City ART Street	
	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in and manner stated.	he time, date and place, and my opinion, death occurred a	due to the cause(s)	and manner as sta	ated.	
	29b. Signature and title of certifier	9c. License number O.C.M.E.	AAC .	d. Date signed (M pril 22, 2009	onth, Day, Year)	
Ø	30. Name and address of person who completed cause of death After 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 1111					
Stat Registra	te 31. Date filed (Month, Day Year) 32. Registrar's Signature are APR 2 4 2009 June 5. January			·		

Physician /Medical Examiner

1 - For State Registrar

Nikoleta Doukouris 2009 6:40 A 22 April 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Chevy Chase Montgomery 3113 Winnett Road If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Hours Months Days 1 □ M 2 🗓 F 579-90-5170 65 Director August 14, 1943 Greece Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a State 10h Counts 28a-f show traumatic event, the Medical Exerciner must be notified at 1 ☐ Yes 2 X No Director Montgomery Chevy Chase Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with ö 20815 3113 Winnett Road United States items 23a Funeral Pages 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎇 No Black, White, etc. 1 ∏Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 X No Specify. Specify: 3 White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Hairdresser Salon 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Aristomenis Kyriakopoulos Eleni Rousos ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important; if item 27 Is any injury or other trau 3113 Winnett Road, Chevy Chase, Maryland 20815 Demetrios Doukouris / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition April 27, 1 X Burlal 2 ☐ Cremation 3 ☐ Removal from State Parklawn Memorial Park 2009 4 ☐ Donation 5 ☐ Other (Specify) Rockville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. Garmhan M01546 7557 Wisconsin Avenue, Bethesda, Maryland 20814 MON Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Small cell cancer of cervix 15 Months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the ası IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No Month Year Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 9 Unknown sate has been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 X No 2 No 1 ☐ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 \(\text{Nursing Home} \) 1 \(\text{Specify} \) Residence \(6 \) Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Deatl 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 □Yes 2 □No death. 2 Accident after death Director: 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D23600 April 23, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5

DHMH 17 Rev 1/2001

State Registrar Bruce Kressel, M.D.

31. Date tiled (Month, Day, Year)

32 Registrar's Signature

5530 Wisconsin Avenue Suite 1125, Chevy Chase, MD 20815

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	Olaro or Marylana	Cer	tificate of l	Death		Reg. No. 2	009	13	100
	Physicia	an	1. Decedent's Name (First, Middle, Last	Roscoe		Estep,	Tr	2. Date of Dea	19 Day 200	no ^{Year}	3. Time of 6:12	Death P M
	/Medic	al	4a. Facility Name (If not institution, give				Location of Death	Aprii		ty of Death	0:12	PW
)	Examin	er	7528 Holabird Av			Dunda:				Ltimor	e Co.	
	Funeral Director		234-54-8253	x	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birti (Month, Day April	h , Year) 25 , 1935	9. Birthp Coun Wes	lace (State of try) t Virg	
	filed within 72 hours after death with the Maryland Hygiene. Wher than "natural", or items 23a or 28a-f show ant, the Wardell Erapher must be notified a	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Batter 10e. Street and Number	altimore 10c. City,	Town or Loc	ation 10f. Zip Code	Dundalk		10g. Citizen o		0d. Inside Cit 1 ☐ Yes	
	th with		7528 Holabird Av	7e.			21222		Unit	ed St	ates	
980	be filed within 72 hours after death with the Marylan tat Hygiene. d other than "natural", or items 23a or 28a-f show event, the Widel Exa, increment to notife dis	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 \(\subseteq \) No If Yes, Give Year or Dates:		Vas Decedent of H Yes, specify Cuba □Yes 21 No	ispanic Origin? (Span, Mexican, Puerto Specify:	ecify Ye's or No- Rican, etc.)	14. Ra BI Spec	ace - Americ ack, White, e ify: Whi	etc.	
2-0	72 ho	letec	15. Decedent's Edi (Specify only highest grad	ucation le completed)	(Give I	ent's Usual Occup kind of work done o OO NOT use retired	durina most of worki	ng	16b. Kind of	Business/Ind	dustry	
12	within lene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		1der	1)		Stee	el Ind	ustry	
פַ	e filed al Hyg other vent,	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Name		Maiden Surna			
<u> </u>	2 should be filed within and Mental Hygiene. is marked other than aumatic event, the M	To [Roscoe Estep,					1 McLau	_			
Baltimore, Maryland 21215-0036	s 1 and 2 should of Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relationship (7 Mrs. Peggy M. Es	tep (Wife)	752	8 Holabi		Dunda1k	, Mary	Land	21222	
Jore	Pages 1 nent of H int: If iter iry or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐			sition (Name of natory or other place)ate	20c. Location	•		and
Saltin	permit. Pages Department of Important: If it any Injury or o		4 ☐ Donation 5 ☐ Other (Specify 21. Sign fur, 1 Funeral Service Licens		22	Name and Addre	Cem. 4/23 ss of Facility k Funeral	Home o	f Dunda	alk, I	Maryl Inc.	and
			23a Part 1. Enter the disease comp shock, or heart failure, set only of Immediate Cause (Final		Do not ente	7922 Wise	e Ave. Dr	undalk,	Mary1a	and 2	1222 Approximate Interval Bety Onset and D	ween
	Physician /Medical Examiner		disease or condition resulting in death)	a. Due to (or a conseque		Cam	ce V				Monte	<u>~~</u>
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a conseque	ence of):							
b .	rtificate be executed ng physician and as the burial-transit	l Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a conseque	ence of):							
68760,	icate b physic the bi	Medical		d								
O. Box	law requires that the death certific as been signed by the attending p 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal of the pregnant at time of de 9 □ Unknown	death 3	Ectopic pregnanc Other (specify)	у			ate of delive		'e ar
rds, P.	luires that n signed b rid be deta	by	Part II. Other significant conditions of	entributing to death but not result	ting in the ur	nderlying cause giv	en in Part I.		obacco use co ⁄es 2 □ ⊀o			
Vital Records,	stclan: The law requir s certificate has been s irector, page 2 should	Completed						24a. Was autop perfor 1 🗆 Yes	rmed?	o. Were auto prior to co death? 1 □Yes	psy findings a mpletion of ca 2 🗷 No	available ause of
Zi S	sician certifi rector,	Be	25. Was case referred to medical examiner?	Hospital:		Oth	26. Place of Deatler:					
ō	iding Phys th. : After this funeral dir	n: To	27. Manner of Death	28a. Date of Injury	28b. Time of	t 3 ∐ DOA 3 million 28c. Injur	er: 4 □ Nursing Ho	me 5 Residence 128d. Describe 1			ý)	
io	Attending death. ctor: Afte	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Day, Year)	Injury		k? Yes 2□No					
Division of	al or Attending Physician: The s after death. I Director: After this certificate had in by the funeral director, page	Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, stre	eet, factory, office		28f. Location (5 City or Tow		nber or Rura	l Route Numi	ber,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical (ysician: To the best of my know iner: On the basis of examinati and manner stated.)
	To the Comp	Me	29b. Signature and title of certifier	We -		29c. Licens	tlb14	+	29d. Date sign	ned (Month,	Day, Year)	9
	841		30. Name and address of person who of	4920 G	Eunliel	1 1761	l B	Hiver	· ms	212	136	
	Sta Registr		31. Date filed (Month, Day, Year) APR 24 2009	22 Pogietrar's Signatu	ire							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** England - Dansicker 200 Danelle Anida /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** Birthplace (State or Foreign Country) 8. Date of Birth (Month, Dav. If Under 1 Year | If Under 24 Hrs 5. Social Security Number Age (In yrs. last birthday) **Funeral** 11/19/1956 52 Maryland Director 213-70-6198 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ortant: If Item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Pikesville Baltimore Md10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 21208 U.S.A. 4 Schloss Court 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. nt: If Item 27 is marked other than "natural", or ite 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Local Elementary/Secondary (0-12) College (1-4 or 5+) Government - Fire Dept Division Chief - Fire Dept. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be Holden Anida T., William В. England, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4 Schloss Ct. Pikesville, Md. Samuel L. Dansicker / Husband Department of Healt Important: If Item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge Cemetery 4/25/09 Pikesville, Md. 22. Name and Address of Facility
Ruck Towson Funeral Home, 21. Signature of Buneral Service Licen Island Towson Fuller In Home, Inc. 1050 York Rd Towson, Md 212 islands, it complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, it is an inclusion of the complex control of the complex cause on each line. Approximate Interval Between 23a. Part 1. Enter the shock, or heart Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) or Attending Physician; The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Es, outcome of pregnancy

Live birth 2 Fetal death

Pregnant at time of death 3 Ectopic pregnancy Day in the past 12 months?
1 Yes 2 No 5 Other (specify) Unknown 23e. Did tobacco use ontribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Tes V No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one Be examiner? Hospital: Other: 4 \sum Nursing Home 1 Inpatient 2 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) မ 28c. Injury at Work? 28d. Describe how injury occurred 27. Manger of Death 28a. Date of Injury 28b. Time of Certification: 5 Pending investigation (Month, Day Year) Injury Natural 1 Natural
2 Accident 1 🗌 Yes 2 🗌 No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

of Vital Records, P.O. Division 24 hours after death. Funeral Director: At completely

State

Registrar

Medical

31. Date filed (Month, Day, Year)

Brian

29b. Signature and title of certifier

29a. Certifier

(check only

32. Redistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Houston

within 2

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

License number

29d. Date signed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 5 per fh g891 5-6-09 vt.
State of Maryland / Department of Health and Mental Hygiene

For Amend Item 25 per me,g890,04/23/09dhb
Registrar

Reg. No. 2 1 1 0 1, Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Lois Jeanette Eller /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Tanklin Square
Social Security Number 6. S BaHmore 8. Date of Birth (Month, Day, Year) March 24,1938 9. Birthplace (State or Foreign 7. Age (In vrs. last birthdav) **Funeral** Months Days Hours Min. -34-3555 1 □ M 2√x F 71 Virginia Director Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show at 1 ☐ Yes 2 ☐XNo Examiner must be notified Director Maryland Baltimore Dundalk 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 7733 Charlesmont Road 21222 'natural", or Items 23a United States within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ŽŽNo If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimoré, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: If Yes, Give Year or Dates: Specify: þ 3 XWidowed 4 ☐ Divorced White Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than " Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. 12 Years Year Homemaker Own Home permit. Pages 1 and 2 should be filed of Department of Health and Mental Hygin Important: If item 27 Is marked other any Injury or other traumatic event, it 17. Father's Name (First, Middle, Last) unkn • 18. Mother's Name (First, Middle, Maiden Surname) Be Evereane Layne ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9078 Walthan Woods Road Carney, MD Michael A. Eller (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Sacred Ht. of Mary Cem.4/17/2009 4 ☐ Donation 5 ☐ Other (Specify) Dundalk, Maryland 22. Name and Address of Facility
Duda-Ruck Funeral Home of
7922 Wise Ave. Dundalk, N 21. Signature of Funeral Service Licenses Dundalk, D 21222 Inc. Ant1. Enter the disease, our implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arresponds, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): odural hematoma ERTIFICATION AT THE STATE OF THE PARTIES OF THE PAR Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine VIOpath the death certificate be executed burial-tran and Due (or as a consequence Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month 5 ☐ Other (specify) signed by the a Ö 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ ESRD on HI 1 Yes 2 No 3 Probably 4 Vunknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an cate has page 2 s autopsy performe certificate 2 1 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner?
1 A Yes 2 No director. Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day Year) After thi funeral (27. Mayner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No reral Director: A 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Manth, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 BC 10 Franklin Square Drive Baltimore, MD 31. Date filed (Month, Day, Year) State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			_ For	State of Mai	yland / I	Departm	nent of F	Health	and Me	ntal Hy	giene		
			State Registrar			Certific	cate of	Death	7		Reg. No.	2009	13104
	Physicia	an	1. Decedent's Name (First, Middle, La	ist)					2.	Date of Dea Month	Day	Year	3. Time of Death
	/Medic			ID FOLE	Y					pril	21,	2009	5:00 P. [™]
4	Examin	er	4a. Facility Name (If not institution, given			4b.	City, Town, o	r Location	n of Death			ounty of Death	
محميس			Gilchrist Hospid		(In the last b	inth days) If I	Tow Inder 1 Year	son	er 24 Hrs. 8.	Date of Bir		Baltimor	e lace (State or Foreign
	Funeral			sex / Age 1 □ M 2 X F	(In yrs. last bi 87		nths Days	Hours	Min.	Month, Da	ı <i>y, Y</i> ea <i>r)</i>	Coun	try)
	Director		219-18-4807 Usual Residence of Decedent		07				U	ше о,	194.	L Mary	Tanu
	land ow		10a. State 10b. County		10c. City, Tow	n or Location	1					1	0d. Inside City Limits
	Mary Fied	ģ	Maryland Baltim	re	Lan	thervi	11e						1 □Yes 2 → No
	r 282	Director	10e. Street and Number				f. Zip Code				10g. Citize	en of What Coun	try?
	h with		400 Fox Chapel D	r.			2	21093	3			U.S.A.	
	be filed within 72 hours after death with the Maryland that Hyglene. d other than "natural", or items 23a or 28a-f show event, I'm Medical Examiner must be notified at	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S.	13. Was D	Decedent of H	lispanic C	Drigin? (Specif	y Yes or No	- 14	4. Race - Americ Black, White, e	
9	or ite	F	1 ☐ Never Married 2 ☐ Married	1 Types 2 □ No			es 2 No	Specif		,,		Propify:	
2-003	ural",	d by	3 ☐ Widowed 4 🕅 Divorced	Year or Dates:			21			-		WI	ite
2	72 h "natu	Completed	15. Decedent's E (Specify only highest gr	ducation ade co <i>mpleted)</i>	168	. Decedent's (Give kind o	of work done	during mo	ost of working		16b. Kind	d of Business/Ind	dustry
2121	vithin sne. than	ם	Elementary/Secondary (0-12)	College (1-4or 5+		Grants	OT use retire Admin	•	ator) Departi	ment of St	ate Planning
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Maryland	be de	Be		_						Easto		Ramsav	
2	d 2 should be th and Mental 7 is marked of traumatic ev	2	Harry F. Rei 19a. Informant's Name/Relationship		19	h Mailing Add	dress (Street					Town, State, Zip	Code)
<u>B</u>	l 2 s h ar 7 is trau	1	M. Ramsay Bell	(daughter)		-						nd 21204	
ē,	es 1 and of Health item 27 r other t		20a. Method of Disposition	(daugitter)		of Disposition ery, crematory			Date			ation - City or To	
ᅙ	Pages nent of int: If it		1 XBurial 2 ☐ Cremation 3 E			ery, crematory n Park		1	5-1-0	ω	Do1+	imoro	Maryland
altimore,	artme	10	4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice		LOUGOI								Maryranu
Ba	permit. Page Department of Important: If any injury or once,	4. 3	De Inger O Co	14		Mito	hell-V	Viede	efeld F	unera.	1 Hom	e, Inc.	21212
			23a. Part 1. Enjer the disease, or con	nplications that caused to	he death. Do							тутапи	Approximate Interval Between
7.5		8 6	shock, or heart failure. List only Immediate Cause (Final	one cause on each line									Onset and Death
****	Physician /Medical		disease or condition resulting in death)	a. We tasked			vaina	MA	POLA	5/e 01	vari	an i	months
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	34 4	ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence	ol).			200	N. Ja	Shop ?	JAC	
19.	d d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	6				20	200/8		" M		
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9	rtifica ng ph as th	Med	IS SERVICE.					4	X	0			
Box	leath certific attending p	an/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o		h 3□Ecto	opic pregnanc	//			23	3d. Date of delive	
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Ś	uires that the de signed by the a d be detached f	þ	Part II. Other significant conditions			400	*	ven in Par	t I.		1/	r	ne cause of death?
or G	w requir s been s should	ted	gait institution win	1 talls, hip to	active i	ACTA Y	epair			1 🗆	Yes 2	NO 3 Prot	pably 4 Unknown
Records,	e law r has be	Completed								24a. Was auto			psy findings available mpletion of cause of
_	Th ate pag	Š								perfo	rmed? 2 No	death? 1 □ Yes	2 □No
Ħ	sician: The la certificate ha irector, page 2	Be (25. Was case referred to medical examiner?						ice of Death (Check only o	one)		
Division of Vital	hysic his o	2	1XYes 2 □ No			outpatient 3	LI DOA					• • • •	n hospice
_	ding Phys h. After this funeral dir	ë	27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injury (Month, Day,	Year) 28b.	Time of Injury	28c. Inju Woi		.	d. Describe	how injury	occurred	
<u> </u>	Attendi death. ctor: A	cati	2 Accident investigation	1 Chillery		VNKN		Yes 2		Fall			
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	To the Hospital or Attending Physician: within 24 hours after dead or To the Funeral Directors After this certific completely filled in by the funeral director,	edical	(Check only 2 Medical Exa	hysician: To the best of	examination a								
	the thin 2 the mple	Med	one) 29b. Signarqre and title of certifier	and manner stat	ea.		29c. Licens	se numbe	ar .		29d Date	signed (Month,	Dav. Year)
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	9		30. Name and address of person who	completed cause of de	670 (Item 23a)	/ (Type, Print)	Church	VI C	+ The	VSON	MA	21204	J.
y 6	Sta	te_	31. Date filed (Month, Day, Year)	32. registrar		1 / 0	201011	V . 1	, , , ,			0,007	
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5	a. racility ivalle (11 1101 1115				.D.	4b. City, Town, o	r Location of De		4c.		4:45
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Physician Macrical Examinor CLEN MEADOWS HEALTHCARE CENTER 46. City, Town, or Location of Death 5. Social Security Number 6. Sex 7. Age (in yrs. last birthday) 100. City 1			yland								
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Exam	that initiated events resulting in death) Last C. Due to (or as a consequence of):										
ian/Medi	23b. Was decedent pregna in the past 12 months	ant 23	1 Live birth	2 Fetal de	eath 3		şy .		2		*
lysic	1 ☐ Yes 2 No 9 ☐ Unknown			at time of dea	ui 5L	_ Other (specify) _					
	Part II. Other significant co	onditions cont	ributing to death I	out not resultir	ng in the ur	nderlying cause giv	ven in Part I.	23e. Did	tobacco u	se contribute to	the cause of dea
E -	COPI	<u> </u>						_ 1□	Yes 2	No 3□ Pro	obably 4 🗌 Un
Comple	CHE	_ (G	ngest	we h	eart	fallen	·)	— aut	opsy formed?	prior to death?	completion of cau
n	25. Was case referred to m examiner? 1 ☐ Yes 2 ☐ ★6	<u> </u>	spital:	- 0 = 5		Ott		Death (Check only			
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ätic	2 Accident	Pending nvestigation	(WOTH), D	ay, rear)	Injury		Yes 2□No	-			
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edical	29a. Certifier (Check only 20 Me	ertifying Physi edical Examin	er: On the basis	of examination	n and/or in	vestigation, in my	opinion, death c	lace, and due to the courred at the time	e, date and	place, and due	to the cause(s)
	29b. Signature and the of	certifier	and manner s	ialeu.		29c, Licens	se number		29d. Dat	e signed (Month	n, Day, Year)
	W.	1/00				Ros	79544		4	122/2	009
3		erson who co	npleted cause of	death (Item 23	3a) (Type,	Print)	H+ . A	Ste 209	100°	on Me	21254

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ORIGINAL

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		-	For State Registrar				a. y.a		rtificate of		•	Reg. No	-2 A A	9	13100
			1. Decedent's Name								2. Date of D	eath Da	ay Ye		3. Time of Death
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-	Examin		4a. Facility Name (I	f not institutio	on, give street	and number)				or Location of Dea		40	. County of D	Death	
-			3156 Gr						Silv If Under 1 Year	er Sprin		inth		gome	ery ce (State or Foreign
e	Funeral		5. Social Security N 135-10-9		6. Sex 1 ☐ M 2		ge (In yrs. la	<i>ist birthd</i> ay) Yrs.	Months Days			Day, Year,)	Country	Jersey
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	yland Jow		10a. State	10b. County	/		10c. City,	, Town or Lo						10d.	. Inside City Limits
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	or 28	Dire	10e. Street and Nur	10f. Zip Code					10g. Citizen of What C						
	ath w	la	3156 Gracefield Rd						(Dit)/	United Star					
	er de	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 ☒ Married 1 ☐ Never Married 2 ☒ Married 1 ☐ Never Married 2 ☒ Married 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Never Married 2 ☒ Married				ban, Mexican, Pu	erto Rican, etc.)	10-	14. Race - American Black, White, etc					
36	rs aft	ا ۾ ا	1 □ Never Married 2 ☑ Married 1 ☑ Wes 2 □ No If Yes, Give 1 □ Yes ※☑ No Specify: 3 □ Widowed 4 □ Divorced Year or Dates: W W II							Specify:		White			
21215-0036	72 hours after death with the Maryland natural", or items 23a or 28a-f show dieal Evaniner must be notified at	ted	(0	15. Deceder	nt's Education	-1-4	1	16a. Dece	dent's Usual Occu	ipation	vorking	16b. I	Kind of Busine	ess/Indus	stry
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and	be fill hta! H ed oth	B	17. Father's Name David			Erod	lerick	5		Ida	ame (First, Middi May		einer		
Σ	2 should be filed withir and Mental Hygiene. is marked other than aumatic event, here	٩	19a. Informant's N		rison		TELICK		ng Address (Stree	1				ite. Zip Ci	Code)
re, Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. tiem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, in a Wedical Evantiner must be notified at		Helen A				e	1	Gracefi						
	ges 1 and 2 t of Health If item 27 i or other tra		20a. Method of Dis	position			20b. Pla		osition (Name of matory or other pl		Date		Location - City		
mo	Pages nent o nt: If		1 XX Burial 2 l 4 □ Donation			al from State	·			· /. / ·	28/2009	Sil	ver Sp	ring	, MD
Baltimore,	permit. Pages 1 Department of I Important: If ite any injury or of		4 Donation 5 Other (Specify) 21. Signature of Fineral Service Licensee 22. Name and Address of Facility Rapp Funeral & Cremation Services 933 Gist Ave., Silver Spring, MD 20910										10		
	TEXT !		23a Part1 Entert	NAMAN	V >				JJ CIDE		TYCE DOI				
			abank as bee	ine disease, o	or complication	is that cause	d the death.	. Do not er	ter the mode of dy	ing, such as card	liac or respiratory	arrest,		l Ir	Approximate nterval Between
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Registrar DHMH 17 Rev 1/2001

State

GRACEFIELD RD, SILVER SPRING

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 02:00AN Months I L EYear 9 **Physician** Joseph Gordon Funk, Sr. /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4c. County of Death imore Examiner If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08/18/1927 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Days Months 1 X M 2 □ F Maryland Yrs Director 81 216-20-6273 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County or than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 1 No Director Dundalk MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21222 7618 Cedar Rd. Funeral hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🔀 No Specify: Specify: White þ WW II 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) within 72 (Give kind of work done during most of working life. DO NOT use retired) nd 2 should be filed within 7 alth and Mental Hygiene.
27 is marked other than "n traumatic event, the Med Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing Mechanic 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gierczak Veronica Funk Daniel ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health a
Important: If item 27 is
any Injury or other trau Dundalk, Maryland 21222 7618 Cedar Rd. Ruth M. Funk (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 04/22/2009 22. Name and Address of Facility Duda-Ruck Funeral Home of of Funeral Service Licensee Signal Dundalk, MD 21222 Dundalk, Inc. 7922 Wise Ave. Approximate Interval Between Onset and Death 23a. Part 1 Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) STENOSIS AORTIC **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): be executed and burial-t Due to (or as a consequence of) physician s the burial Box 68760, Physician/Medical as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy Month Day Year ģ in the past 12 months? 5 Other (specify) 2 No P.0. 9 Unknown signed by t Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performe certificate 2 No 1 ☐Yes 2 ☐No 1 Yes tal or Attending Physician: T is after death.

al Director: After this certificated in by the funeral director, pa 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 12 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 624 hours a To the Hospital within 24 hours a To the Funeral C completely filled filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c, License number D30263 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7601 OSLER DRIVE TOWSON. MARYLAND 21204 FRANCIS KHOO Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

09-02618 Der

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

errick A. Frazee	4.	State of Maryland / Department of Health and Mental Por State Certificate of Death	iygierie	Reg. N	0.	
	Re	istrar	2. Date of	Death		3. Time of Death
Physician/	-	Decedent's Name (First, Middle,Last)	Month April 2	, 2009	/ rear	1545 hrs
ledical Examine	4	Derrick A. Frazee Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Deat			4c. County of Dea	
	4a	Laurel Regional Hospital		l	Prince Georg	·
	.	7 Age (In vrs. last birthday) If Under 1 Year If Under 24H		of Birth(M	M/DD/YYYY) 9. E Fore	sirthplace (State or
Funeral Director	5.	Social Security Number 6. Sex Months Days Hours Mi	In. Jul	y 13	, 1959 ^c	Maryland
	<u> </u>	usi Decidence of Decedent				10d. Inside City Limits
any		la. State UNK 10b. County Unk 10c. City, Town or Location			unk	unk 1 Yes 2 No
- 0 M						
th the Maryland 23a or 28a-f sho notified at once	8 -	De. Street and Number unk 10f. Zip Code	unk	10g. (Citizen of What Co	ountry?
Mar Mar	ě				IISA	
th the		Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes	or No-	14. Race - Am White, etc	erican Indian, Black,
th wi	Funeral	Armed Forces? If Yes, specify Cuban, Mexican, Fue	no Rican, el	G.)		
r dea	፤	Yes 2 No specify:			1 '	white
ral!	≦⊢	Tor bales: 1450 Decedent's Lisual Occupation (Give kind of	of work done	16	b. Kind of Busine	ss/Industry
hour hour	- [월	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+)	(emea)			
36 in 72 han dical	읪	12 0 painter			contrac	ting
with her t	Completed	7. Father's Name (First, Middle, Last)	ame (First, M	liddle, Mai	den Surname)	
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	Be	Milda	red Ne	1son		tete Zin Codo)
212 ould be Ment mark	oΓ	Donovan Byron Frazee Jr 9a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number	or Rural Rou	ite Numbe	er, City or Town, S	tate, zip code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	-	10102 Faris SHop I	Road H	ager	Ctown M 20c. Location - Cit	or Town, State
and 2 and 2 lealth tem 2 traus	-	20a Method of Disposition	Date	· ·	200. Location - Oil	y 0. 101 e.e
Ore ges 1 of H		1 Burial 2 Cremation 3 Removal from State				
Baltimore, MD oemit. Pages I and 2 sh Department of Health and important: If item 27 is injury or other trauman	-	4 Donation 5 X Other Specify: in state 21. Signature of Funeral Separce Licensee Ronald Separce Wade Divertor State Anatomy Boa	65	E 1.7	Paltimo	ro Street
Sal ermi bepar mpo		21. Signature of Funeral Service Licensee Ronald S. Wade Director State Anatomy Boa	ara 65 1201	у w •	Daitimo	te btreet
	-	Renard S. Wade Dave util State Anatomy Both Baltimore, MD 21 26a. Part Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardi	iac or respira	tory arres	t, shock, or heart	Approximate Inter Between Onset a
Physician Medical	- 1	failure List only one cause on each line. Immediate Cause (Final disease a. Complications of chronic alcohol	abuse	2		Death
aminer		Immediate Quse (Final disease or condition resulting in death) Due to (or as a consequence of):				
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	-	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
<u> </u>	اڃًا	cause. Enter Underlying Cause C.				
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Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate by within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the but	Physician/M	1 Yes 2 No 9 Unknown g Unknown				
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of Vital Rec Ing Physician: The I After this certificate I	o Be	examiner? Hospital: 1 Inpatient 2 V ER/Outpatient 3 DOA	Nursing Hon		Residence 6 how injury occurre	
of V Phy ter th	Ĕ	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work		Describe	now injury occurre	
on C nding th. :: Af	Certification:	1 X Natural 5 Pending				Dural Doute Number
SiO Atter	cat	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc	. 28f.	Location (or Town, §	Street and Numbe State)	r or Rural Route Number,
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he Ho in 24 he Fu	ica	one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occ	curred at the	time, date		
To the within comp	Medical	and manner stated. 29c. License number			29d. Date signe	ed (MOHIII, Day, rear)
	2	O.C.M.E.			April 3, 200	9
		Hamely Victorial, May				
		30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltim	ore, MD 2	21201		
		Pameia E. Southall, MD 718818411111111111111111111111111111111				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 3. Time of Death つじし 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** DVI Mary V. Fogle /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Glen Burnie Anne Arundel Baltimore Washington Medical Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month Pay, May 28) 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 □ M 2 🔯 F Months 219-62-1232 53 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h County 10a State 1 □Yes 2 □ No Director MD Anne Arundel Glen Burnie 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 983 Shoreland Drive 21060 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎇 No 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify Specify: White à 3√ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) diabled none 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Samuel Hook Dorothy Curtis ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Robin Forbes/daughter 2017 Bear Ridge Road #2 Baltimore, MD 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 3 Removal from State 1 ☐ Burial 2 ☐ Cremation 4 Donation 5 ☐ Other (Specify) State Anatomy Board 655 W. Baltimore Street 21. Signatur Runn Triced icense de, Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lipe. Approximate Interval Between Onset and Death avivive Immedia Cause (Final disease or ondition resulting in death) 10 as a consequence of) 00 Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 212No 1 Yes 25. Was case referre o medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manuer of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

law requires that the death certificate be executed attending physician and for use as the burial-tran Box 68760, P.O. | s been signed by the should be detached Division of Vital Records, cate has by page 2 sl certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the fredical Exercises must be redified at

Department of Health a important: If item 27 is any injury or other tra once.

Physician /Medical

Examiner

72 hours after

f and 2 should be filed within Health and Mental Hygiene. and Mental Hygiene.

of Health

Pages 1

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Maryland

Baltimore,

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Physician/Medical Completed Be

> Natural 2 Accident

> > (Check only one)

5 Pending investigation 6 Could not be determined 3 Suicide 4 Homicide

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 301 NOSpital Drive,

State Registrar

Medical

31. Date filed (Month, Day, Year)

24

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Depart State	rtment of Health and N <i>tificate of Death</i>		0000	10110
			Registrar 1. Decedent's Name (First, Middle, Last)	——————————————————————————————————————	2. Date of Death	g. No. 2	3. Time of Death
	Physicia		Joseph Thomas Fittipald	i	Month April 2	Day Year	8:03 P M
-	/Medic Examin			4b. City, Town, or Location of Death	**PTTT *	4c. County of Death)
			9210 Shelton Street	Bethesda		Mont	gomery
	Funeral Director		293-01-6326 18 M 2	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, April 5,	Year) 9. Birth Cou	place (State or Foreign untry)
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loca	ation			10d. Inside City Limits
ni	Maryl -f sho	tor	Maryland Montgomery	Bethesda			1 ☐ Yes 2 🛣 No
Giamptroni ,	th the Marylan or 28a-f show	Director	10e. Street and Number	10f. Zip Code	109	g. Citizen of What Cou	intry?
npt	th with		9210 Shelton Street	20817		United	States
ਜ਼	r dea	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 ☑ Married 1 ☑ Yes 2 □ No ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	as Decedent of Hispanic Origin? (Sp Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
9	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, it is Medical Evan	by	1 Never Married 2 No Married 1 No 200	□Yes 2X No Specify:		Specify:	White
Dale 5-003	72 hou	sted	(Charify anly highest grade completed) (Civa ki	ent's Usual Occupation ind of work done during most of work	ring .	6b. Kind of Business/li	
2	vithin 7	Completed	Elementary/Secondary (0-12) College (1-4or 5+) Admini	onoruse retired) strative Law Judg	, 1	Federal Gov Private Pra	
64	filed v Hygie Ither t		17. Father's Name (First, Middle, Last)	ney	e (First, Middle, Ma		
Cleared Maryland	ld be ental ked o ic eve	To Be	Frank Fittipaldi	Julia	Pocabello		
lea ary	shoul and M mar	F		Address (Street and Number or Rur		-	ip Code)
	and 2 saith a 127 is		Mary Claire Fittipaldi/Wife 9210 S	Shelton Street, B	ethesda,	Maryland 2	20817
ore	es 1 a		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposic cemetery, crema	ition (Name of atory or other place)	Date 20	Oc. Location - City or T	own, State
Ĕ	Pages iment of I tant: If ite		4 □ Donation 5 □ Other (Specify) Arlington Na	tional Cemetery 200)9	rlington,	
Baltimore,	permit. Pages Department of Important: If if any Injury or once.		21. Signature of Funeral Service Licenses Molecular Mol	Name and Address of Facility Rob thesda-Chevy Chas thesda, Maryland	pert A. P Se Inc 20814-35	umphrey Fu 7557 Wisco 01	neral Home/ onsin Avenue
			23a. Firt Inter the disease, or complications that caused the death. Do not enter show, or leart failure. List only one cause on each line.				Approximate Interval Between
4	Physician		Immediate Cause (Final disease or condition Chronic Obstructiv	ve Pulmonary Dise	ase		Onset and Death
4	/Medical Examiner		Due to (or as a consequence of):				
		ē	Sequentially list conditions, if any, leading to immediate	sease			
.5	uted J insit	Examiner	cause. Enter Underlying Cause (Disease or injury Tschemic Cardiomyo	pathy			
٦,	exectin and ial-tra	Exa	that initiated events resulting in death) Last c. Due to (or as a consequence of):	<u> </u>			
,	ate be nysicia he bui	edical	d				
39	ertifica ing pl	Med	IF FEMALE:			4	
O. Box	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months?	Ectopic pregnancy Other (specify)		23d. Date of deli Month	very Day Year
P.O.	that the		Part II. Other significant conditions contributing to death but not resulting in the und	derlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
Division of Vital Records,	quires n sign lid be	d by	Diabetes		1 X Yes	2 □ No 3 □ Pro	obably 4 ☐ Unknown
00	s bee	olete			24a. Was an	24b. Were aut	topsy findings available
æ	The Iz	Completed			autopsy performe 1 ☐ Yes 2	ed? death?	ompletion of cause of 2 ☐ No
ita	stan: ertifica ctor, §	BeC	25. Was case referred to medical	26. Place of Deat	th (Check only one)		
>	ding Physician: The Ih. After this certificate hit funeral director, page	2	examiner? 1 🖸 Yes 2 🗆 No Hospital: 1 🗀 Inpatient 2 🗀 ER/Outpatient			ice 6 Other (Spec	eify)
Ę.	ing P	on:	27. Manner of Death 1 △ Natural 5 □ Pending 28a. Date of Injury 28b. Time of Injury	28c. Injury at Work?	28d. Describe how	v injury occurred	
sio	ttend death ttor: /	icati	2 Accident investigation 3 Suicide 6 Could not be	M 1 Tyes 2 No	29f Location /Ctro	eet and Number or Ru	ral Pauta Numbar
Div	affor A affer Direct	Certification	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)	st, lactory, office	City or Town,		rai rioute ivanibei,
	e Hospita 124 hours e Funera letely fille	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or invegant and manner stated.				
	To th withir To th comp	Me	29b. Signature and title of certifier	29c. License number	290	d. Date signed (Month	, Day, Year)
	1.		- Levi Colon	052862		April 22	2, 2009
	20 X		30. Name and didress of person who completed cause of death (Item 23a) (Type, Pi		150 153	-PEROWEI-G	22 - 10 I
	ン		Kevin Dorrance, M.D. 8901 Wisconsin 31. Date filed (Month, Day, Year) 32. Registrar's Signature	Avenue, Bethesda,	, Marylan	d 20889	
	Sta Registr		31. Date filed (Month, Day, Year) APR 2 4 2009 32. Registrar's Signature APR 2 4 2009	racked			
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 17 PM 4 21 2009 David Leigh Griffin /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Rosedale FRANKLIN SQUARE HOSPITAL CENTER If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year)
Aug. 26, 1955 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1⊠M 2□ F 53 Baltimore, MD. Director 220-62-3677 Usual Residence of Decedent 10d. Inside City Limits and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene. 10c. City, Town or Location 10b. County 10a State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shot traumatic event, the Medical Examiner must be notified at 1X Yes 2 □ No Director Maryland N/A Baltimore 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 21206 United States 4760 Elison Ave. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: White ģ 3 ☐ Widowed 4 ₺ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiens. Important: If item 27 is marked other than 'na any Injury or other traumatic event, It a Medic once. College (1-4or 5+) Elementary/Secondary (0-12) Truck Driver Trucking 11 n/a18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Norbert L. Griffin Frances Anna Haynes ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (Niother) Mrs. Frances Anna(nee Haynes)Griffin 4760 Elison Ave. Baltimore, Maryland 21206 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition April 25, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Evans Funeral Chapel 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland 22. Name and Address of Facility Peaceful Alternatives Funeral&Cremation Ctr.,P.A. 2325 York Road Timonium, Maryland 21093 , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Arrhythmia Physician Fatal /Medical Due to (or as a consequence of): Examiner HyperKalemia
Diu to joras a consequence of: Sequentially list conditions. Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Renal failure Due to (or as a consequence of): Physician/Medical Sepsis IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 ☑No 2 □No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

> State Registrar

Medical

29a. Certifier

(Check only

29b. Signature and title of certified

and manner stated.

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

54428

-21-09

30. Name and address of person who completed caus of death (Item 23a) (Type, Print)

9000 FRANKLIN SQUARE DR Balto md 21237 3 PIPKIN Michael

31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 8:10PM craine 2000 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Kaltimore DWSON If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Days Months 1□ M 2 F 93 Yrs. 217-26-6710 Director 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the IN-acel Examiner must be notified at 1 Yes 2 No Baltimore Director MD 10g. Citizen of What Country? 10f. Zip Code Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 No 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 BIACK If Yes, Give Year or Dates: Specify: þ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0,12) College (1-4or 5+) Dental 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t of Health and Mental Hy f item 27 is marka Edward Corbin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) arriage walk Ct. Granddauahler 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ot Burial 2 ☐ Cremation 3 ☐ Removal from State Ridge Condru 4-23-09 Pikesville, Mb Druid 4 ☐ Donation 5 ☐ Other (Specify) Vougho C. Greene Funeral Sils 21. Signature of Funeral Service Licensee Vaux Randallstown, Mesus ibertu 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart bailing. List only one cause on each line. Immediate Cause (Final months **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): as the burial-transi Exami and Due to (or as a consequence of): Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 🗌 Ectopic pregnanc in the past 12 months? Month Dav Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, FRACTURE 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) WOSPILL Certification: To To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director; After this completely filled in by the funeral dir 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. M nner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural Full UNHONOWN 1 ☐ Yes 2 No APRIL 3 2009 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

NV/31NG NOWE 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 700 W. FORTIETH ST, BALTIMBREMD Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number APRIL 18 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N. Charles 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No./ 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) April 20^{Day} Physician 2009 3:00P. M Melvin Gruber John /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Riverview Care Center Essex 8. Date of Birth Sept1, 1913 if Under 1 Year_ If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. Maryland 1**⊠** M 2□ F 95 213-05-5158 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinat roust be notified at Y⊟Yes 2 □ No Director Baltimore City Md. 10g. Citizen of What Country? 10e Street and Number death with U.S.A. 21224 308 Imla Street Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 14. Race - American Indian. 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene.

is marked other than "natural", or ite 1 Never Married 2 Married Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🕍 No Specify. White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Beth Steel Police Officer 7th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ellie Dent John Gruber ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 an Imla Street Baltimore, Maryland 21224 <u> Catherine Gruber (wife)</u> Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition M Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery 4-23-2009Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Licensee Take 21222 1201 Dundalk Avenue Baltimore, <u>Md.</u> 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Let only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician eumonic disease or condition resulting in death) /Medical (or as a consequence of). Examiner Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last OsteoarThri and the burial-tran Due to (or as a consequence of) physician Physician/Medical attending ph IF FEMALE If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) ed by the a 9 I Unknown s been signed b should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 🗙 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t perform 1∐Yes 2⊠No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🖾 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After t **X**Natural 5 Pending 1 ☐Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, s after death.

I Director: After fully the fully set after fully the full set after full set af filled in within 24 hours a

To the Funeral I

completely filled

> State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature ind title of certifie

address of person who completed cause of death (Item 23a) (Type, Print) ebastian K. John, M.D. 3023 Eastern Avenue Baltimore, Md. 21224 Sebastian K. 2. Registrar's Signature 31. Date filed (Month, Day, Year) 2 4 2009

and manner stated.

M.O

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D 55171

29d. Date signed (Month, Day, Year)

April 21, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Frantina Margaret Holton 11:50A M 22,2009 Apri /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Baltimore 5021 Sunset Road If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day) **Funeral** Year) Days Months Hours 1 □ M 2√2 F Director 163-26-7689 20. 1930 W. Virginia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h County ral", or items 23a or 28a-f show Examiner must be routifud at N/A Baltimore X Yes 2 □ No Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or: any injury or other traumatic event, the Medical Experiment ment be no any injury or other traumatic event, the Medical Experiment ment be no 21215 USA 5021 Sunset Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ▼No 1 □ Never Married 2 □ Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Yes, Give Completed by 3€ Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dept of SocialService Food Stamp Intake Worker 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lillie Glen Raymond Campbell ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Sunset Road Baltimore, Maryland 21215 5021 Kevin Holton/ Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greenmount Cemetery 4/28/09 Baltimore, Maryland 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature 5240 Reisterstown Rd Baltimore, Md 21215 ra disease, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, failure. List only one cause operated line. Approximate Interval Betw art 1. Enter the shock, or hear failt Immediate Caus (Final Onset and Death **Physician** disease or condition resulting in death) /Medical sequence of): Examiner 0 Ve Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine death certificate be executed sician and burial-tran Due to (or as a consequence of): physician the burial Physician/Medical attending p IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month in the past 12 Day Year 5 Other (specify) signed by the a d be detached fo o. 9 Unknow ٣. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant of nditions contributing to death but not resulting in the underlying cause given in Part I. Records, 9 1 □ Yes 3 Probably 4 Unknown been si should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate 1 ☐Yes 2 ☐No 1 □ Yes 2 [Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 \sum Nursing Home Hospital: ome 5 Residence 6 □ Other (Specify)
28d Pescribe how injury occurred 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ this After thi 27. Manner of Augustural 2 Accident 28a. Date of Injury 28b. Time of 28c. Injury at Work? Certification: (Month, Day, Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No death. n 24 hours after death.

E Funeral Director: A pletely filled in by the fu 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 \(\text{Homicide} \) 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner state within 2 To the I 29d Date signed (Month, Day, Year) 29c. License number

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year,

2 4 2009

32. Registrar's Signature

| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Day, Year) | June 14, 10 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 XX M 2 □ F 213-18-1192 86 1922 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show must be notified at MD Baltimore Baltimore Highlands Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23a or Pages 1 and 2 should be filed within 72 hours after death with 21227 2804 Ohio avenue United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 □Yes 2X No Specify: þ If Yes, Give Year or Dates: 3 X Widowed 4 □ Divorced "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)

Postal Worker Elementary/Secondary (0-12) 12 College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 is marked other tha any injury or other traumatic event, the 1 once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Haven Louise Wilder ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances Gorth Daughter 2724 Beaver Creek Crossing, Powder Springs, GA 30127 20b. Place of Disposition (Name of Glen Haven 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4-14-2009 Glen Burnie, Maryland 4 Donation 5 ☐ Other (Specify) Memorial Park Ambrose Funeral Home, Inc. 21. Signature of Funeral Service Lice 2719 Hammonds Fry Rd., Lansdowne, MD 21227

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximately Course (Final) Immediate Cause (Final **Physician** Acute Myocardial Infarction
Due to (or as a consequence of) disease or condition resulting in death) /Medical **Examiner** Due to (or as a consequence of): Heart Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy 5 Other (specify) signed by the a o 9 Unknown ۵.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28a. Date of Injury (Month, Day, Year)

and manner stated

Hospital:

5 ☐ Pending investigation

6 ☐ Could not be

determined

Charles

C.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 1 per dr., g913,03/15/2011dhb

Amend State of Maryland The Bod of State of Maryland Mental Hygiene Certificate of Death

Hayen Sr.

4b. City, Town, or Location of Death

Baltimore Highlands

2. Date of Death

April 10, Day 2009

4c. County of Death

Baltimore

3. Time of Death

9:30 A

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 □Yes 2X No

Birthplace (State or Foreign Country)

Maryland

14. Race - American Indian, Black, White, etc.

Specify: White

U.S.P.S.

23d. Date of delivery Year Month Day 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 Î Ne 1 □ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical

Completed by

Be

Certification: To

1 - For State Registrar

Physician

/Medical

Examiner

1. Decedent's Name (First, Middle, Last)

2804 Ohio Avenue

Hayen,

4a. Facility Name (If not institution, give street and number)

Charles A.

To the Hospital (within 24 hours a) To the Funeral D

Division of Vital Records,

certificate

Director:

Registrar

Day, Year) APR 24

Demento

25. Was case referred to medical examiner?

1 Yes 2 No

27. Manner of Death Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and

705 Registrar's Signatur

0063145

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year) 0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury

SUITEG Plaital Drive

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State	State of Mary		artment of F <i>rtificate of</i> .		Mental Hy		00 10116
	¥	Registrar Decedent's Name (First, Middle, La	st)	00	Timoate of	Death	2. Date of De		3. Time of Death
Physicia /Medic		Virginia Ruth	Harpham				Month April 1	.3, 2009	4:30 A M
Examin		4a. Facility Name (If not institution, given	re street and number)		4b. City, Town, o	r Location of Deat		4c. County	
	÷	Manor Care of Che 5. Social Security Number 6. S		a um la at hinth da u	Chevy C	hase If Under 24 Hrs.	O Data of Bi		gomery
Funeral Director			I∏M 2527F	n yrs. last birthday, Yrs.	Months Days	Hours Min.	(Month, Da	0, 1917	Birthplace (State or Foreign Country) Indiana
D		Usual Residence of Decedent				1	Dec. 1	0, 1917	Tudiana
arylar show	'n	10a. State 10b. County		c. City, Town or L					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
the M 28a-f	Director	DC 10e, Street and Number		Washingto	10f. Zip Code			10a Cidman at 14	
a or the r		5354 43rd Street	. NW		2001	5		10g. Citizen of W	mat Country?
death	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?	r in U.S. 13.	Was Decedent of H		pecify Yes or No)- 14. Race	e - American Indian,
re, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Health and Mental Hygiene then "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		1 Never Married 2 Married	1 ☐ Yes 2 X No If Yes, Give		1 ☐ Yes 2 No	Specify:	to riican, etc.)	Specify.	k, White, etc.
5-0036 72 hours aff	ed by	3 ☐ Widowed 4 M Divorced 15. Decedent's E	Year or Dates:	16a Dece	dent's Usual Occup	ation		16b. Kind of Bu	Caucastan
215. In 72 nin 72 Nedic	plet	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	kind of work done DO NOT use retired	during most of world)	rking	lob. Kilia di Bu	siness/industry
2121(Completed	Liententary/Secondary (0-72)	4	L V	olinist			Sympho	ony Orchestra
ind be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last				18. Mother's Nar	ne (First, Middle	, Maiden Surnam	θ)
Maryland Id 2 should be file Ith and Mental Hy 77 Is marked oth traumatic event	P	Pyrl John Harphan 19a. Informant's Name/Relationship		405 34-33			Whitake		
and 2 steath an n 27 Is ner traur		Evelyn Harpham, I	,		ng Address (Street I. Danvil				
		20a. Method of Disposition		20b. Place of Dispo	sition (Name of		Date		City or Town, State
imor Pages nent of I		1 ☐ Burial 2 【A Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci.	Removal from State	Funeral (Chantilly	matory or other place Choices o	f 4/1	17/2009	Chantil	ly, Virginia
Baltimore, permit. Pages 1 a Department of Hea Important: If item any injury or othe		21. Signature of Lun, rai 3-vice Lice			2. Name and Addre			Funeral	
		Midmy	M0096						, VA 22307
	S 10	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on each line. Metastatic			ig, such as cardia	or respiratory a	rrest,	Approximate Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)							
Examiner			Due to (or as a co	insequence or,					
P ==	ner	Sequentially list conditions, if any, leading to immediate caus. Enter Underlying Cause (Disease or injury	Due to (or as a co	nsequence of):					
and and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C	-0				- <u>-</u>	
'60, be ex sician sician s			Due to (or as a co	insequence oi):					
Box 68760, Seath certificate be executed attending physician and for use as the burial-transit	edical		_d						
Box sath cert attending for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf p 1 ☐ Live birth 2 ☐		∃Ectopic pregnancy			23d. Date	e of delivery
e death	Sicie	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at time		Other (specify)	,		Mor	nth Day Year
P.O. hat the de do by the a letached		9 ☐ Unknown Part II. Other significant conditions	contributing to death but no	ot resulting in the u	nderlying cause giv	on in Part I	23a Did	obacco usa contri	ibute to the cause of death?
or Vital Records, Physician: The law requires that this certificate has been signed trail director, page 2 should be det	d by	, and the other original contains to	onalizating to doday but he	or roodining with the d	ndenying dadde giv	on in race.			3 Probably 4 □Unknown
cord w requir been si	Completed						24a. Was		Vere autopsy findings available
Re lay	omo						auto perfe 1 Yes	psv p	rior to completion of cause of leath?
Vital Ristination: The certificate hirector, page	BeC	25. Was case referred to medical examiner?				26. Place of Dea			□Yes 2□No
or V physic this ce	70	1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient	2 ER/Outpatie		er: 4 Nursing H	lome 5□Resi	dence 6 □Othe	er (Specify)
On O dlng Ph .r After th funeral		27. Manner of Death 1 Matural 5 □ Pending	28a. Date of Injury (Month, Day Ye	ear) 28b. Time o	Worl		28d. Describe	how injury occurre	∍d
Division or Attending after death. Director: After	ertification:	2 Accident investigation 3 Suicide 6 Could not b		At home farm str		Yes 2 ☐ No	29f Location /	Street and Number	er or Rural Route Number,
Div A after I Dire	ertit	4 ☐ Homicide determined	building, etc. (S	Specify)	cot, ractory, office		City or To	wn, State)	y or nurar noute Number,
5 8 8 9 1	OI	29a. Certifier 1 ☐ Certifying Pl	nysician: To the best of m	y knowledge, deat	h occurred at the tir	me, date and place	e, and due to the	cause(s) and mar	nner as stated.
the H nin 24 the Fo	Medical	one)	niner: On the basis of exa and manner stated.	ammadon and/of ir	1		ured at the time,		
To with	2	29b. Signature and title of certifier	/\ I\\		29c. Licens	-	263	29d. Date signed	(Month, Day, Year)
	-	30. Name and address of person who	MU	(Itam 2021)		05/28	0	4/1	6/09
7		Anushiravan Dad			1	o. Suite	206 Pa	ckvilla	MD 20050
Stat	te	31. Date filed (Month, Day, Year)	32 Registrar's	Signature	and I	· Juile	200, KC	ckviile,	IVID 20830
Registra	-	APR 24 20	09 Serve	Signature .	ura				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death HALLIDAY Month ELIZABETH 2:30AM APRIL 22 20091 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Howard County General Hospital Columbia Howard If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) October 17, 1934 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) Months 1 □ M 2 🗶 F 400-78-1636 Pennslyvania Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Howard Ellicott City Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21043 U.S.A. 8704 Wethered Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 20 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 Tes 2 No Specify: Specify: White 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hugh Stewart Mary Gregg 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 8704 Wethered Drive, Ellicott City, MD 21043 Daniel Parks / Son-in-law 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Spring Grove Cemetery 04-29-2009 Cincinnati, Ohio 22. Name and Address of Facility Ruck Towson Funeral Home 1050 York Road, Towson, Maryland 21204 o not enter the mode of dying, such as cardiac or respiratory arrest, S NDR6 CApproximate Interval Between Onset and Death RESPIRATORY ACUTE Due to (or as a consequence of): PHEUMONIA BILATERAL Due to (or as a consequence of)

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

à

Completed

Be (

Funeral

Director

r than "natural", or Itams 23a or 28a-f show the Medical Examiner must be notified at

should be filed within 72 hours after deeth v nd Mental Hygiene. marked other than "natural", or Itams 236

snould be filt.

permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked o any injury or other treumatic eve once.

Baltimore, Maryland 21215-0036

with the Maryland

certificate be executed

Examiner

use as the burial-transi attending physicien and for use as the burial-tran signed by the a has page 2 s the funeral director. After after death. filled in by

Division of Vital Records, P.O. Box 68760,

or Attending

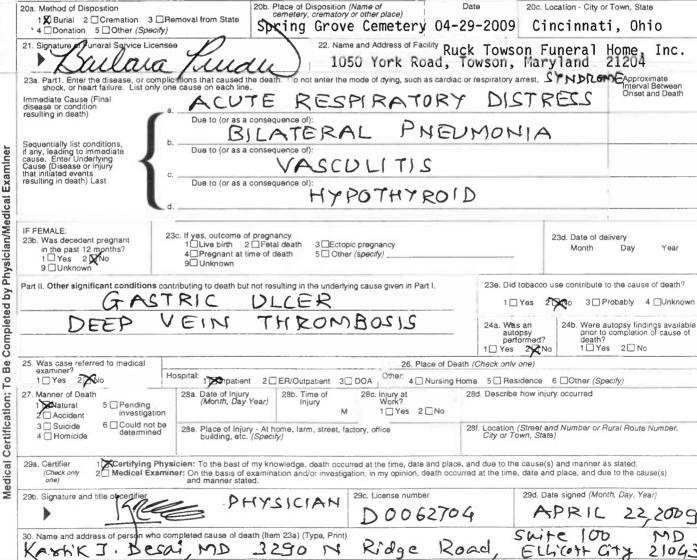
24 hours a

within 24

completely

30. Name and address of pers

31. Date filed (Month, Day, Year)



State

Registrar

park

3290

n who completed cause of death (Item 23a) (Type, Print)

32. Pegistrar's Signature

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#16a&18perFH, G890, 4730/09, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Year **Physician** 009 homas John /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltimore University of Maryland medical Cent 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. Social Security Number Birthplace (State or Foreign Opuntry) 7. Age (In yrs. last birthday) **Funeral** Min. Months Days 1**X** M 2□ F Hours -58-6986 Director yland Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits ns 23a or 28a-f show 1XYes 2 □ No Director MOr 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 1 ann of Health and Mental Hygiene.
anti If item 27 is marked other than "natural", or items 23a or in yor other than than that I have that main to work, the Medical Evanther main than I yor other thatmatic event, the Medical Evanther main than Funeral n94 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 □Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 X No Specify Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Millwright/ Elementary/Secondary (0-12) College (1-4or 5+) Planner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lurlena ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21229 Bulto. Ma. ubi Department of Heal Important: If item 2 any injury or other once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 23a. Part i Enter the dease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** sepsis 3 doys /Medical Due to (or as a consequence of): Examiner neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) physician the neral Director; After this certificate has been signed by the aftending prifiled in by the funeral director, page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐No 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an autopsy performed? Yes 2. Wo 1 ☐Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only one) and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License numbe 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5. St. Baltimore MD atherine Smì Greene 21201 31. Date filed (Month, Day, Year, 32. Registrar's Signature State APR 2 4 2009 Registrar

09-03208 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Kenneth Johnson State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 2. Date of Death Physician/ 1. Decedent's Name (First, Middle, Last) Month Day April 21, 2009 **Medical Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) NIA Johns Hopkins Bayview Medical Center Baltimore If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year **Funeral** Foreign Days Hours Min. Months Director 9-68-6905 1 M 2 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or cation , or items 23a or 28a-f show r must be notified at once. Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black 11 Marital Status must be 1 Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married Yes f Yes. Give Year Yes 2 No specify: Specify Widowed Divorced traumatic event, the Medical Examiner marked other than "natural", ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b, Kind of Business/Indust Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 NIA 18.Mother's Name (First, Middle, Maiden Surname) John Sox Be 1001 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print If item 27 is Lohnson reensbe 20b. Place of Disposition (Name of cemetery, 20a, Method of Disposition crematory or other place) 1 Burial 2 Cremation portant: Doneston 5 Cem Other Specify 0 22. Name and Address of Facility 21. Sign by re of Funeral Sirvic r complications that caused the death. Do not enter the mod f f dying, such as cardiac or respiratory arrest, shock, or heart **Physician** the disease. falur. List only one cause on each line /Medical a. Gunshot Wound of Torso Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and tran Physician/Medical the attending physician ed for use as the burial -UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? icate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy certificate has death? performed? ✓ Yes 2 No 1 🗸 Yes the Hospital or Attending Physician: 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 2 V ER/Outpatient DOA Nursing Home 5 Residence 6 Inpatient After this 2 1 Yes 28a. Date of Injury 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 27 Manner of Death Certification: Apr 21, 2009 Subject shot 1 Natural 2014 hrs Yes 2 V No Pending Director: 2 Accident Investigation filled in by 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide or Town, State) 5110 Hillburn Avenue, Baltimore, MD determined 4 V Homicide (Specify) Porch the Fineral 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year)

Time of Death

2052 hrs

10d. Inside City Limits

Yes 2 No

Approximate Interval

Between Onset and

Death

Year

Νn

April 22, 2009

31. Date filed (Month, Day, Year) State Registrar

Patricia Aronica-Pollak MD.

32. Begistrar's Signature

Assistant Medical Examiner

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

Name and address of person who completed cause of death (Item 23a)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death 3. Time of Death **Physician** unnson /Medical 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ba Himore 8. Date of Birth 3 9 ay, Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Number last birthday) **Funeral** Months Hours 1 □ M 2 🗶 F Days Director Usual Residence of Decedent within 72 hours after death with the Maryland 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Mes 2 □ No Director timore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 21207 indsoc "natural", or items 23a Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 □No þ Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during life. DO NOT use retired) Health and Mental Hygiene. dary (0-12) College (1-4or 5+) Eather's Name (First, Middle, Last, 18. Mother's Name (First Be Pages 1 and 2 should be 19b. Mailing Address (Street and Number or Informant's Name-Relationship permit. Pages 1 and 2 a Department of Health a Important: If item 27 is any Injury or other trau \sim 20a. Method of Disposition 1 KBurial 2 ☐ Cremation 3 ☐ Removal from State Donation 5 ☐ Other (Specify) NFuneral Service Licer 23a. Part1. Enter the Usease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Alcheimers end-Stage /Medical Due to (or as consequence of) Examiner Sequentially list conditions Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760, physician sthe burial Physician/Medical attending philosopher at the second IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 Other (specify) signed by the a P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate of Vital 1 □Yes 2 □ No 2 🖳 Klo 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 ☐ No 4 Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral of 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0057465 15Rumpamemp 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 200, Reisterstown, MD. 21136 15 KajapakseMD 25 Main St.) Suite 31. Date filed (Month, Day, 32. Registrar's 6ignatu

DHMH 17 Rev 1/2001

State Registrar

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			1 - State Registrar		Cei	rtificate of I	Death		Reg. No.	009	13141	
	Physici	an	1. Decedent's Name (First, Middle, Last Francis A.	Topica				2. Date of D	Day	Year	3. Time of Death	
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Deat	HAPRI	L 2)	2.000 County of Death	00 10 AM	
and the same of th	- Admin	IGI	NORTHWEST HO	SPITAL		RANDA	LISTOLIN			ALTIM	ORE	
Ī	Funeral Director		5. Social Security Number 219 · 16 · 1533 Usual Residence of Decedent	x M 2 ☐ F 7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		irth Pay, Year) 1925	9. Birth Cou	place (State or Foreig Intry)	
	ryland how	_	10a. State 10b. County		y, Town or Lo						10d. Inside City Limits	
	he Ma 28a-f s	ecto	MD Howar	d \	Mood						1 □Yes 2X No	
	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "fadical Even and a substituted at the market of the control of	Funeral Director	10e. Street and Number 1994 Village Gyes	en Drive		10f. Zip Code	21163		10g. Citize	en of What Cou USA	ntry?	
	tems ?	nner	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (S an, Mexican, Puerl	Specify Yes or N to Rican, etc.)	0- 14	1. Race - Amer Black, White.		
0000	urs afte	ğ	1 Never Married 2 Married 3 Widowed 4 Divorced	1∭Yes 2 ☐ No If Yes, Give Year or Dates:		1⊡Yes 2⊠No	Specify:		S	Specify: 3	ack	
ה ה	72 hou	eted	15. Decedent's Edu (Specify only highest grad	cation e completed)		dent's Usual Occup kind of work done o		rkina	16b. Kind	d of Business/Ir	ndustry	
7	filed within 72 hours Hygiene. other than "natural", ent, the medical Ex-	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	`life.` l	DV (Jet		9	_	Trucki	7g	
ב	ld be filed with ental Hygiene ked other tha ic event, the fi	Be Co	17. Father's Name (First, Middle, Last)	10/14		271001	18. Mother's Nar	ne (First, Middle	e, Maiden S	urname)	<u> </u>	
yla	should b ind Ment marked umatic e	2	Altired Jenifer				Marga		buse	y	D.114 -	
2	and 2 sho ealth and n 27 is m		19a. Informant's Name/Relationship (T) Mary C. Tonifer	(pe. Print)	19b. Mailir	ig Address (Street a	and Number or Ru 30 SV CL	ural Route Numi	ber, City or 1	Town, State, Zi	p Code) 21163	
ָׁרָ ב	es 1 and 2 of Health fitem 27 i		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ F	20b. F	Place of Dispo	sition (Name of natory or other place	e)	Date	20c. Loca	ation - City or T	own, State	
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g	permi Depar Impor any in		21. Signature of Fune al Service Licens	Ü	22	Name and Addres	-	The second second			neral SVCs D 21133	
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused the death	h. Do not ent	er the mode of dyin				0017 194	Approximate Interval Between	
-	Physician		Immediate Cause (Final disease or condition resulting in death)		ohstav	etive Pu	Imonary	disea	se		Onset and Death	
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3	ertifica ing phr e as th	Medi	IF FEMALE:									
0.00	the Hospital or Attending Physician: The law requires that the death certificate be thin 24 hours after death certificate be the 14 hours after death. The functor After this certificate has been signed by the attending physicial mpletely filled in by the funeral director, page 2 should be detached for use as the burn	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c 9 ☐ Unknown	I death 3	Ectopic pregnancy Other (specify)	/		23	d. Date of deliv	very Day Year	
6	ires that signed b	by Ph	Part II. Other significant conditions con	ntributing to death but not resi	ulting in the ur	nderlying cause give	en in Part I.	23e. Did	tobacco use	e contribute to	the cause of death?	
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5	an: Th tificate tor, pay	o i	25. Was case referred to medical		,		26. Place of Dea	1 □ Yes	2 🖾 No	1 ☐ Yes	2.⊠No	
	hysici his cer I direc	To B	examiner? 1 ☐ Yes 2 ☑ No	lospital: 1.⊠ Inpatient 2.□	ER/Outpatien	t 3 DOA Othe	ar'	lome 5 ☐ Res		Other (Speci	ify)	
	ding Physician: The In. After this certificate har funeral director, page	ion:	27. Manner of Death 1 ☐Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury Work	yat :? Yes 2 □ No	28d. Describe	how injury	occurred		
2	Atten r death ector: by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At ho	me, farm, stre		res 2 🗆 No	28f. Location	(Street and	Number or Rur	al Route Number,	
5	ital or ins afte ral Dir	Cert	4 ☐ Homicide determined	building, etc. (Specify	y) 		<u> </u>	City or To	wn, State)			
:	Hospi 24 hou Funer stely fil	edical	29a. Certifier 1. ☐ Certifying Physical (Check only one) 2 ☐ Medical Exami	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death tion and/or in	occurred at the ting vestigation, in my o	ne, date and place pinion, death occu	e, and due to the arred at the time	e cause(s) a , date and p	and manner as lace, and due t	stated. to the cause(s)	
;	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Mec	29b. Signature and title of certifier			29c. License				signed (Month,	•	
			Nilein Patel n	ער		D 64	1957		April	215,20	109	
7	8		30. Name and address of person who co		23a) (Type, I	Print)	RANDA				VD 21133	
	Sta		31. Date filed (Month, Day, Year) APR 24 2009	32. Registrar's Signa	ture					· · · · · · · · · · · · · · · · · · ·		
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 22, Day 2009 Year Physician MARY KUJAWA 11:05P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Oakcrest Care Center Parkville Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth July 5,1919 5. Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Min. Hours 1 □ M XX F Months Days MaryTand 213-01-6127 89 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f st other traumatic event, "ha Modical Examiner must be notified 1 ☐ Yes 2**Y**No Director Maryland Parkville Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8820 Walther Blvd 21234 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2XXNo Specify. Completed by Specify: White 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Administrator Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Walter Joseph Kujawa Sophie Byczkowski 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8820 Walther Blvd #3505 Parkville Maryland 21234 Christine R Kujawa Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State XBurial 2 ☐ Cremation 3 ☐ Removal from State St Stanislaus Cemetery Apr.27,2009 Baltimore, Maryland ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facily/ITCHELL-WIEDEFELD FUNERAL HOME INC Signature of Funeral Service Licenses nnis XI 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Debelety **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Disease flzhermess Sequentially list conditions, if any leads to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner sician and burial-transit Due to (or as a consequence of) physician certificate be Completed by Physician/Medical as the IF FEMALE use If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 3 Ectopic pregnancy for Month Day Year 4 Pregnant at time of death 5 Other (specify) ned by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ś sign Diabeles Mellifus Type 2 Hyperknsive Heart Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Record 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 ☐ Yes of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide The certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

The death occurred at the time, date and place, and due to the cause(s) and place, and due to the cause(s) are the cause(s). 29a. Certifier and manner stated. 29d. Date signed (Month, Day, Year) CRAP, MISH ompleted cause of death (Item 23a) (Type, Print) 8800 Walther Blud, Parkville MO 21234 Hadrison State Dark Registrar

KUJAWA,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene? [] [] 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month **Physician** 8:25 AM 202 F. April Mary Krause 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Towson, Maryland
If Under 1 Year If Under 24 Hrs. Baltimore Genesis Multimedical Certer 7700 York Rd. 21204 8. Date of Birth (Month, Day, Year)
Sept. 17,1921 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 ☐ M 2 🔀 F Months Days Hours 87 213-34-3638 Maryland Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location rthan "natural", or items 23s or 28s-f show the Medical Exerciper must be collified at Dundalk 1 ☐ Yes 2 HNo Maryland Baltimore Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 29 Lombardy Drive United States 21222 by Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes ZX No Specify: 3 K Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 9 Years Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ie marked o Mary V. Baran Anthony Gall ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29 Lombardy Drive Dundalk, Maryland Health tem 27 (Daughter) Barbara Edler item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ŏ Department of Important: If it any injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4/23/2009 Baltimore, Maryland Oak Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final **Physician** a Congestive Heart Failure disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner b. Atheroscierate Cardiovascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last years Due to (or as a consequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit type II Diabetes Mellitus ue to (or as a consequence of): Box 68760, physicien Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of deliven 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. certificate has been signed by the a rector, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 ☐ Yes 2 ☐ No 3 Probably 4 Munknown Completed 24a. Was an autopsy performed 24b. Were autopsy lindings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 1 No director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☐ No this After the funeral Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation after death Director: A 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours aft To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Muchelle E. Kalender CRNP 2097104 4/20/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michelle E. Kalendek, CRNP Genesis Multimedical Center 7700 York Road Towson, Maryland 21204 Registrar's Signature 31. Date filed (Month, Day, Year) known

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2009 Month **Physician** 0523PM April Kande /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Randallstown Baltimore Northwest Hospita If Under 1 Year 1 If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 3 M 2 ☐ F Months 216-72-9655 50 Dec. 6, 1958 Director Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Experient rust be notified 1 ☐ Yes 21 No Director Maryland | Baltimore Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code should be filed within 72 hours after death with 6917 Dogwood Road 21244 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? · 1 ☐ Yes 2 ★ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 ⅓ If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married altimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify. Specify: White **∂** 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Warehouse Supervisor 12 Distribution 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jerry Kandel Gladys Wilson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any Injury or other trau once. Pages 1 and 2 Susan Kandel Wife 6917 Dogwood Road; Baltimore, MD 21244 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4/24/2009 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cemetery Woodlawn, Maryland 22. Name and Address of FacilitySterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 LIC 153 MO Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Myocardia disease or condition resulting in death) /Medical Due to (or as a confequence of): Examiner Coronal Sequentially list conditions, if any, leading to infine data cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☑ No Day 4 Pregnant at time of death 9 Unknown 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 1 X Yes 2 □ No 1 12 Yes 2 □ No funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) 1 Tes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 after death.

I Director: Aff d in by the fur filled in by 24 hours a within 24 hor To the Fune completely f the

 Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated.

onel

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year) 29c. License number 2009 M50526

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rd Randallstown 5401 Old Deborah Belc 31. Date filed (Month, Day,

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Richard George Krause 21, 2009 7:58a M April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Annapolis Anne Arundel Anne Arundel Medical Center If Under 1 Year | If Under 24 Hrs. Social Security Number . Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours M 2□ F 355-18-7503 81 Director $_{
m IL}$ 6/29/1927 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show r than "natural", or items 23a or 28a-f sho 1⊈Yes 2 No Director MD Anne Arundel Edgewater 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 420 Hamlet Club Drive Unit 307 21037 USA Funera Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 2 should be filed within 72 hours after and Mental Hygiene.
Is marked other than "natural", or ite Affried Polices! 1 ⊠Yes 2 □ No WW II If Yes, Give Year or Dates: US Navy 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes 2X No þ 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Entertainer Entertainment 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item Z7 is marked oth any liqury or other traumatic event once. Mable Pederson Arthur Krause 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9725 Wild Fire Lane, Owings, MD 20736 Paul A. Mikkola / Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Ardent Crematory 4/23/2009 Hanover, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 21. Signature of Funeral Service License Dorota Marshall Marsha Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): spital or Attending Physician: The law requires that the death certificate be executed ours after death.

neral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit Exami Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 2 No o 9 Unknown 9 Unknown Division of Vital Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. \$ 2 200 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 □Yes 2.2 Two 1 □ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 2 XNo 1 Propatient 2 □ ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours 29a. Certifie 1 🕽 🤇 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 2 of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day,

Year)

2 4 2009

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death **Physician** Morris J. Lake 2009 April 12:53 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Oak Crest Care Center Parkville Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Year) | July 17,1915 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 1 X M 2 □ F 215-07-1100 93 Ohio Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 힏 MD Baltimore Parkville 1 ☐ Yes 2 X No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8800 Walther Blvd. 21234 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore Elementary/Secondary (0-12) College (1-4or 5+) Vice President of Sales Business Forms 12 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Morris Lake Nellie Harris 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 200 Mary Jane Lane, Bel Air, MD 21015 Naomi Dickerson/ Niece 20b. Place of Disposition (Name of Du Cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State 04/27/09 Timonium, MD Memorial Gardens 4 ☐ Donation 5 ☐ Other (Specify) Evans Funeral Chapel & Cremation Services 8800 Harford Rd. Parkville, MD 21234 21. Signature of Funeral Service Licensee Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or healt failure. List only one cause on each line. Im e rate Cause (Final dise de or condition DEMENUTIA END SIAGE resulting in death) Due to (or as a consequence of Sequentially list conditions, if any leading to immunicate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to for as a connectionos of resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Completed Inknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 25. Was case referred to medical examiner? Be 26. Place of Death (Check only on Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Veath
12. Natural
2 Accident 28a. Date of Injury (Month, Day, Year) Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier tive Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated.

Box 68760, þe Ö Records. Vital of Division

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Baltimore, Maryland 2121

MCRRI

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Funeral

Director

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Item 27 is marked other than "natural", or Items 23a or 28a-f sk other traumatic event, the Medical Examinar must be notified

12 should be filed with and Mental Hygier 7 is marked other the

permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is,
any Injury or other trau

Physician

/Medical

Examiner

burial-t

physician at the burial

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page

been has e 2 s certificate or Attending Physician: After the death. I Director: after within 24 hours a

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BRAZIER M. 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

egistrar's Signature

WALTHER

29c. License number

Bild

29d, Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Mar	yland /		rtment of F tificate of			,	giene Reg. No/	2009	13127
.00	Physici	an	Decedent's Name (First, Middle, Las.	100						Date of Dea	- (Year	3. Time of Death
400	Physici /Medic	al	4a. Facility Name (If not institution, give	etract and number)		Т	4b. City, Town, o	r Location	of Death	pril	7	200 County of Dea	1
į.	Examin	er	Copper RI	dae			Syke	SVI	ile			arr	011
	Funeral Director		5. Social Security Number 6. Security 169–14–2435	7. Age ((In yrs. last l	birthday) Yrs.	if Under 1 Year Months Days	If Under Hours	Min.	Date of Birth (Month, Day eb 28	, Year) 192	Co	thplace (State or Foreign ountry) PA
ļ.,	ס		Usual Residence of Decedent 10a. State 10b. County	1	10c. City, To	own or Loc	cation			CD 20	1 /2		10d. inside City Limits
	Maryla I-f shov	tor	VA Fauquier		Warre								1 □ Yes 2 □XNo
	filed within 72 hours after death with the Maryland Hygiene. kher than "natural", or Items 23a or 28a-f show ant, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number 6593 Rapidan Cou	ırt			10f. Zip Code 20187				10g. Citiz US	en of What Co	ountry?
	ems 23	ınera	11. Marital Status	12. Was Decedent Ev Armed Forces?		13. V	Vas Decedent of H f Yes, specify Cubi	lispanic Or an, Mexica	rigin? (Specify an, Puerto Ric	/ Yes or No- an, etc.)	. 1	4. Race - Ame Black, Whit	
336	al", or It	by Fu	1 ☐ Never Married 2 ☐ Married 3 💢 Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:		1	□Yes 2□No	Specify	<i>/:</i>			^{Specify:} wh	ite
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Maryland 21215-0036	ould be file Mental Hy arked othe	Be	17. Father's Name (First, Middle, Last) Edward Jenkins					1	ner's Name <i>(F</i> . Kulp	irst, Middle,	Maiden	Surname)	
aryl	should and Men s marke rumatic	J.	19a. Informant's Name/Relationship (7	ype. Print)	I .		g Address (Street	and Numb	ber or Rural R				Zip Code)
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mor	Pages nent of I nt: If Its iry or o	1	1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	1	-	sition (Name of natory or other place y Cremat:		4-24-0			esville	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licen Page Hough		-		.O. Box						& Chapel
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused the	he death. D								Approximate Interval Between
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that initiated events c. Due to (or as a consequence of):													
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Box	ath cert ttending or use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. if yes, outcome pt 1 ☐ Live birth 2	☐ Fetal dea		Ectopic pregnanc	y			2	3d. Date of de	elivery Day Year
Ö	the deay the a	nysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at ti 9□Unknown	me of death	n 5∟	Other (specify) _						
Records, P.	The law requires that the death certificate has been signed by the attending I agge 2 should be detached for use as	þ	Part II. Other significant conditions of	ontributing to death but	not resulting	g in the ur	nderlying cause giv	ven in Part	1.	23e. Did to			o the cause of death? robably 4 □Unknown
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r Vital	Physiciar this certif al directo	To Be	25. Was case referred to medical examiner? 1 Yes 2 Yo	Hospital: 1 ☐ Inpatient	t 2□ER/	Outpatien	t 3 DOA Oth	or V	ce of Death (Considerated)			3 □Other (Spe	ecify)
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ت	To the Hospital or Attending Physician: The Within 24 hours after death. To the Funeral Director: After this certificate hat completely filled in by the funeral director, page		(Check only 2 Medical Exam	ysician: To the best of niner: On the basis of e	examination								
	To the within 2 To the complete	Medical	one) 29b. Signature and title of certifier	and manner state	ed.		29c. Licens	se number			29d. Dat	e signed (Mon	th, Day, Year)
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	- ₁ 0		30. Name and address of person who Him 5. Dark	er TLOC	breas	ht 1	oud ?	Syk	esvill	e m	1	217	84
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar	's Signature	par	Red						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#30perDVR,G890,4/24/09,WS
State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year Miles McDevitt Nelson 6:50 P M 2009 April 19 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Charlotte Hall Veterans Home Charlotte Hall St. Marys 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/4/1921 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 X M 2 □ F 167-18-7513 87 **Director** Pennsylvania Usual Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Evanister must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 X No Directo MD St. Marys Charlotte Hall 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? 20622 U.S.A 29449 Charlotte Hall Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No þ Specify: White 3 X Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Transportation 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) McDevitt Elizabeth Bostick Nelson ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 301 S. Church St.Apt#102, Snow Hill, MD 21863 Eleanor Taylor/ Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/23/2009 Anatomy Gifts Registry Hanover, Maryland 4 X Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste.P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death immediate Cause (Final Physician ZHET MER'S disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending ph IF FEMALE 23b. Was decedent pregnant in the past 12 months? yes, outcome of pregnancy 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ARTERY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown PERLIPIDEMIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed After this certificate har funeral director, page 1 ☐Yes 2 ☐No 1 ☐Yes 2 🗆 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Injury **U** Natural 5 Pending investigation death 1 ☐ Yes 2 ☐ No 2 ☐ Accident the after death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ determined 4 ☐ Homicide within 24 hours a

To the Funeral I

completely filled filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) WD 20.200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

RAO

31. Date filed (Month, Day, Year) APR 2 4 2009 32. Registrar Signature

Calvert Family Care 14090 HG Trueman Rd. Solomons, MD 20678

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** N 055 2012 REVACE 09 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Prince George's Mitchellville 1404 Brady Court Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 M 2 □ F 5/1/1954 54 Virginia Director 153-48-1663 Usual Residence of Decedent 72 hours after death with the Maryland la or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. Count 1 ☐ Yes 2 X No Director MD Prince George's Springdale 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 20774 U.S.A. 9108 Utica Place 7 is marked other than "natural", or items 23a traumatic event, the Medical Examinationst t Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black ð 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "rany Injury or other traumatic event." Elementary/Secondary (0-12) College (1-4or 5+) Construction Equipment Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Irene Christmas Carter James Henry Moss ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Kidmore Lane, Lanham, MD 20706 Prevace Moss/ Son 7205 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/22/2009 | Hanover, Maryland Anatomy Gifts Registry 4☑ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of uneral Service Licens 7522 Connelley Dr., Ste.P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MONTHS **Physician** SOPH AGEM disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ner Dus to (or as a consequence of) Physician: The law requires that the death certificate be executed Exami attending physician and for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal deat
4 ☐ Pregnant at time of death
9 ☐ Unknown 3 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No signed by the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performe certificate 1 ☐ Yes 2 No 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☐Yes 2☑No HOME, 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ this 28b. Time of Injury . Date of Injury (Month, Day, Year) Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 1 Certification: Hospital or Attending 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2

State

DHMH 17 Rev 1/2001

Medical

APR 24 2009 Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day,

ed cause of death (Item 23a) (Type, F

and manner stated

whe com

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

EFENSE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2009 22. **Physician** Mary A. Mack 7:50 April /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Parkville 3101 California Avenue Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year May 9, 1917 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** Days Hours 91 Yrs. Mary land 212-28-0226 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Mudical Eventhal Eventhal Eventhal Madea. 10d. Inside City Limits 10c. City, Town or Location 10b County 10a. State 1 ☐ Yes 2X No Parkville Baltimore MD Director 10f Zin Code 10g. Citizen of What Country? 10e. Street and Number 3101 California Avenue 21234 U.S.A. Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Lab Technician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Francis Yichter Emma Kreisser 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3101 California Ave. Parkville, MD 21234 Nancy M. Gibson/Daughter 20b. Place of Disposition (Name of Cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 04/25/09 Parkville, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22 Name and Address of Facility Evans Funeral Chapel & Cremation Services 8800 Harford Rd. Parkville, MD 21234 a. First 1. Ent if the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or left failure. List only one cause on each line. Approximate Interval Between Onset and Death Oyea **Physician** Alzhemers disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): and the burial-tran Due to (or as a consequence of): Physician/Medical as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? cate has been signed | page 2 should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate I 1 ☐ Yes 2 ☐ No 1 ☐Yes 2X No ospital or Attending Physician: hours after death, uneral Director; After this certifica 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated.

State Registrar

29b. Signature and title of certific

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

P.O. Box 68760.

Division of Vital Records,

rson who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

Harkville, MD21234

2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** Richard Pearce McCleary P^{M} 23 2009 1:11 April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Baltimore Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2□ F 80 Towson, Maryland 220-20-1250 Director Usual Residence of Decedent 10d. Inside City Limits 10h County 10c. City, Town or Location 72 hours after death with the Maryland 10a State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examiner must be notified at 1 ☐ Yes 2 X No MD Baltimore Director Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 913 Arran Road 21239 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2X Married 1 □ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: White Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 73 th and Mental Hygiene. **7 is marked other than "n**. Railroad Conrail Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Car Distributor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be Cora Elva Hanna Harry McCleary ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
913 Arran Road, Baltimore, MD 21239 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2::
Department of Health a Important: If item 27 is any Injury or other trau once. Norma McCleary/ Wife 20b. Place of Disposition (Name of Duffered Place)
Duffered Valley Memorial Gardens 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 04/27/09 Timonium, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License nd Address of Facility Funeral Harford Approximate Interval Between Onset and Death art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or fleart failure. List only one cause on each line. mm diate Cause (Final Physician On 3 months ase or condition resulting in death) /Medical Due to (or as consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-tra Division of Vital Records, P.O. Box 68760, ζ Due to (or as a consequence of): Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>م</u> DUBALLA 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 2. No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A' 1 ☐Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ss of person who completed cause of death (Item 23a) (Type, Print) e and addre 31. Date filed (Month, Day, 32. Registrar's Signature State

DHMH 17 Bev 1/2001

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 0445PM 2009 APRIL Stanley Carlton McQueen-Bey /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE HOSPITAL N/ASAINT AGNES Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Hours Days 1⊠ M 2□ F Director 219-66-8383 48 Jan 4,1961 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show ?? is marked other than "natural", or items 23a or 28a-f shor traumatic event, it a fredicti Exomitar must be notified at Baltimore 1 Yes 2 □ No Maryland N/A 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21229 1236 Seminole Avenue USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status e filed within 72 hours after de al Hygiene. 1 127 Yes 2 □ No If Yes, Give Year or Dates: XXNever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Speci Black 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Year Technician 12 should be filed with and Mental Hygier 7 is marked other tt <u>Maintenance</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Franklin McQueen-Bey Beaulah Lee 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra once. Franklin McQueen-Bey/Father 1236 Seminole Ave Baltimore, Maryland 21229 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Arbutus Memorial 1 Parial 2 ☐ Cremation 3 ☐ Removal from State Arbutus, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Funeral Service Licer 5240 Reisterstown Road Baltimore, Md 21215 23a. Part 1. Enfer the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CEREBRAL EDEMA **Physician** 1 DAY disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 2-3 DAYS HEPATIC Sequentially list conditions, if any, reading to induce late cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner signed by the attending physician and be detached for use as the burial-transit PANCREATITIS 2-3 DAYS ACUTE Due to (or as a consequence of). P.O. Box 68760 RENAL 2-3 DAYS IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 5 ☐ Other (specify) 1 □Yes 2 □No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown After this certificate has been s funeral director, page 2 should HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was a... autopsy performed? ves 2 No 1 ☐ Yes 2 ☐ No Division of Vital 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To nours after death.

neral Director: After this

filled in by the funeral di 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

State Registrar

STANLEY

MCQUEENBEY,

900 CATON

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KALISETTI

31. Date filed (Month, Day,

P22002

AVENUE, BALTIMORE,

APRIL 19, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Lillie Mae Odessa Manley 12:15 P M 2009 April 9 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Greater Baltimore Medical Center Towson Birthplace (State or Foreign Country) if Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, Date of Birth (Month, Day, **Funeral** Hours Min. 1 □ M 2 🛛 F 240-72-7446 69 Dec. 19. 1939 N. Carolina Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 28a-f show Department of Health and Mental Hygiene important: if item 23a or 28a-f show important: if item 27 is marked other than "natural", or items 23a or 28a-f show important: if item 27 is marked other than my injury or other traumatic event, it. Medical Examination and the mything and proce. XXYes 2□No Director MD N/A Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21215 2703 Oswego Avenue USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes ★★No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black ≥ 3√2 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r ementary/Secondary (0-12) College (1-4or 5+) Nurse Provident Hospital 10th Grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Johnnie Williams Eula Carroll 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Phyllis Manley/ Daughter 2703 Oswego Avenue Baltimore, MD 21215 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Zion Cemetery 4/25/09/ Lansdowne, MD 22. Name and Address of Facility Chatman-Harris Funeral 21. Signature of Juneral Service Licenses Eron 5240 Reisterstown Rd. Baltimore, MD21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) 26AN PATLURE Examiner Ecquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last nsequence of) Physician/Medical Examiner Due to (or as a o the burial-trar Due to (or as a consequence of): attending physician for use as the burla IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 No Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

Division of Vital Records, P.O. Box 68760,

Hospital or Attending Physician: The law requires that the death certificate be executed certificate funeral director. this After t within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Be Certification: To

Medical

State Registrar Hospital

5 Pending investigation

1 Yes 2 No

27. Manner of Death

1 Natural

2 ☐ Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only

29b. Signature and title of certifie

6 ☐ Could not be

1 Inpatient

28a. Date of Injury (Month, Day,

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 ER/Outpatient 3 DOA

28b. Time of

29c. License number

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

1410

2120

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2009 14:27PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JATHI AGHEL HOLDJTAL BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Country) **Funeral** -241 1 □ M 2 1 € Months Director inia Usual Residence of Decedent 10b, County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Evandrian roust be notified at 1 Nes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 212 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 □Yes 2 No þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. em 27 is marked other than Elementary/Secondary (0:12) College (1-4or 5+) 18 cotch Nider 12-10 Pages 1 and 2 should be filed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Starra St. mille dra 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important; If ite any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Cremetory 4-27-09 4 □ Donation 5 □ Other (Specify) of Funeral Pervice Licensed 21. Signat Wallace in. , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Part 1. Enter the diseas shock, or heart failure Approximate Interval Between Onset and Death Myocardia Immediate Cause (Final Infarction Physician veek resulting in death) /Medical Due to (or as a consequence of) Examiner Years COLONALY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical IF FEMALE: ves, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Live birth 2 Fetal death 3 🗆 Ectopic pregnancy Month Day Year 5 Other (specify) ned by the a edetached for 1 ☐ Yes 2 No 9 ☐ Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by VISEUSE Record 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate Renal Vital 1 XYes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA nours after death.

neral Director; After this y filled in by the funeral di Medical Certification: To of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 056226 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 caton Ave Balt more Ballo nichae M. D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** PM 2009 Sara Manns April /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner University of Maryland Medical Baltmart Baltimore Cit (ente Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 18, 1935 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1 □ M 2XX May 216-30-2331 73 Maryland Director Usual Residence of Decedent 10d, Inside City Limits 10h County 10c. City, Town or Location 10a. State Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show usy or other traumatic event, It. Medical Exactions (1912). Baltimore County 1 □Yes 2 No Baltimore Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21234 8500 School Rd. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes XXNo Specify: \$ White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Housekeeping -Own Home Housewife 10 yrs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rose Armetta Salvatore Maggio ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8500 School Rd. Baltimore, Maryland 21234 Calvin L. Manns, Sr. (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition XX Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. Gardens of Faith 4-25-2009 Baltimore, Md. 4 Donation 5 Dother (Specify) ²² Name and Address of Facility E. F. Lassahn Funeral Home 11750 Belair Rd. Kingsville, Md. 21. Signature of Funeral Service Licensee Boch HICH 21087 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician hypovdemic shock hours disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner disseminated coardinath hours intrascular Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the Hospital or Attending Physician: The law requires that the death certificate be executed acric repair hours physician and s the burial-trans thoraco aneurysm Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death
☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 C Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 No Day 5 ☐ Other (specify) sbeen signed by the should be detached 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ distase 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown arter coronary Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b irector, page 2 sh autopsy performed?

1 Yes 2 No renal insufficiency 2 X No 1 ☐ Yes 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1730393521 April 22,2009 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) C JASON LAI MD 22 S Greene St Baltimore MD Zizel

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State

Registrar

31. Date filed (Month, Day, Year)

APR 24 2009

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 00 **Physician** Pri 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1(000 Co. t 30/1200 Johns Hopkins Boyus 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1□M 2×F Months Days Hours D19-18-3858 Usual Residence of Decedent Director 8 Sept 13, 19a1 the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ns 23a or 28a-f show must be notified at 1 Nes 2 No Director Baltimore MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with 1 and of Health and Mental Hygiene.

The filed T is marked other than "natural", or items 23a or: I are traumatic event, the Medical Examiner must be nuy. Boxburg 9190c 5(002 AZU Completed by Funeral Race - American Indian, Black, White, etc. 12: Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify: 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Medica 19 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ Gerald 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nadja 20a. Method of Disposition Ave Annapolis MD 21401 steele 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Pages Department of Important: If it any injury or o 1 ☐ Burial 2 ☐ eremation 3 ☐ Removal from State Baltimore, MD 30-09 etro (rematory 4 ☐ Donation _ 5 ☐ Other (Specify) 21. Signature Fur ral Service License 22. Name and Address of Ficility AM 1333 Mid Valley Dr. Jesup, PA 18434
e mode of dying, such as cardiac or respiratory arrest,

Approximate Interval Between Onset and Death. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. 23a. Partf. shock Embolis Immediate Cause (Final disease or condition 10 minuites Physician mona resulting in death) /Médical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a nonsequence of Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, by Physician/Medical attending p as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day signed by the at d be detached fr 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 25 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown 1mohoma Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an pneumonia autopsy 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Laursing Home 5 Residence 6 Other (Specify) 27 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA ၉ 1 ☐ Yes this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Injury 5 ☐ Pending investigation 1 Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) homa ane 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2 4 2009 Registrar

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Amend #11, 19a, per Inf & 23e, per MD g891 5/13/09 TT

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** Morris 00:00M A. Shannon /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Northwest General Hospital Baltimore Co. Randallstown If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) 70 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Hours Days 1 ☐ M 2 🛣 F Months Maryland 38 218-96-7548 Director Usual Residence of Decedent d 2 should be filed within 72 hours after death with the Maryland thand Mental Hygiene.

27 is marked other than "natural", or items 23a or 28a-f show traumatic event, If a Medical Examiner must be notified at 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 1 □Yes 2 No Dunda1k Director Baltimore Maryland 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 8123 Delhaven Road United States 21222 by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 ☐ Widowed → Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cosmetologist Cosmetician 12 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Wanda Werdebaugh Charles Smarr 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau once. Mr. Michael Morris (Husband) 8123 Delhaven Road Dundalk, Maryland 21222 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State Sacred Ht. of Jesus Cem. 4/21/2009 Dundalk, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk,
7922 Wise Ave. Dundalk, Maryland 21. Signature of Funeral Service Licensee <u>212</u>22 Approximate Interval Between a. Frt 1. Enter the disease, or court shock, or heart failure. List out of lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line Onset and Death Immediate Cause (Final disease or condition resulting in death) Resouration Due to (1) as a consequence of): **Physician** /Medical **Examiner** Distress Syndrama Resouratory Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last uence of): Examiner Due to (or as a cons Acinetobacter Preumonia The law requires that the death certificate be executed ECOIT Sepsis

Due to (or as a consequence of): Cols and and burial-trai attending physician Physician/Medical as the Box IF FEMALE: for use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 1 Live birth 2 Fetal deat
4 Pregnant at time of death 3 Ectopic pregnancy Year Month Day 5 Other (specify) 9 Unknown be detached o 9 Unknown signed by σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ Records, 3 Probably 4 ☐ Unknown Kenal Failure 1 ☐ Yes 2 🕱 No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? Premonis 24a. Was an has autopsy performed page certificate 1 ☐ Yes 2 ☐ No Invavenors 1 ☐ Yes 2 🐼 No Hx at Vital 25. Was case referred to medical examiner? Physician: 26. Place of Death (Check only one) funeral director. Other: 4 Nursing Home 5 Residence 6 TOther (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Medical Certification: To ð After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending 1 🔁 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated. To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier ile ilelle Burton 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. D6bbl6 Bw fm 2835 Sm1th (Hem 23a) (Type, Print) 2835 Smith Avenue Svite 203 Baltimare MD 21209 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

4

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April 22, 2009 **Physician** Peter Joseph Manetto 6:00 AM /Medical 4a. Facility Name (If not institution, give street and number)
Brightview Assisted Living 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Baltimore 8. Date of Birth Month, Day, ADC11 12, 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours New York 1 X M 2 □ F 93 116-01-0413 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner is not be notified at once. Baltimore Baltimore Maryland 1 ☐ Yes 2 No Director 10f. Zip Code 21236 10g. Citizen of What Country? 0e. Street and Number 8100 Rossville Boulevard Apt. 206 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 12 Yes 2 □ No WWII If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Accounting Clerk Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (Mariano Manetto Josephine Manetto ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8100 Rossville Boulevard Baltimore Maryland 21236 Catherine E. Manetto/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Most Holy Redeemer 4/24/09 Baltimore Maryland Repaired Address of Facility 5305 Harford Road Baltimore Maryland 21214 21. Signature of Funeral Service Licensee huster 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 60 Man The disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed nding physician and ise as the burial-tran Due to (or as a consequence of) Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) □Yes 2□No P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 □Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 No 2 ER/Outpatient 3 DOA 4 Nursing Home Certification: To 1 Inpatient 5 Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Injury at Work? 1 Natural 2 Accident 5 Pending within 24 hours after death.

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 41 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, Maryland 21234 9512 Harford Road Suite 4 Mohammad Rahnama, M.D. 31. Date filed (Month, Day, egistrar's Signature Year) State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 15,2009 Melvin /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GNES HOSDITAL 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Security Numbe Date of Birth (Month, Day, Year) **Funeral** 1⊌M 2□F Days Hours 62 Director 212-44-0793 24,1946 Maryland June, Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Contonsville, MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 'natural", or items 23a or USA 21228 Funeral 315 Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural" or item any injury or other traumatic. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Saltimore, Maryland 21215-0036 Specify: Specify: 2 Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) City 12 Laborer Construction -0-17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Cleveland Melvin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, 153 5+. MD 21224 N. Milton laquan da 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Zion Apr 25, 2009 Lansdowne, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ronald A. Grayson Transon 270 orald Fred Hilton Pass a 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician SEVERE BILATERAL BRONGONEUMONIA DAY 5 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine completely filled in by the funeral director, page 2 should be detached for use as the burial-transi and Due to (or as a consequence of): been signed by the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? PSYCHOSIS 1 Yes 2 No 3 Probably Honknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an MEMENTIA autopsy performed? 2 🗌 No Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Yo ဂ္ 1 1 Impatient 2 ER/Outpatient 3 DOA hours after death. uneral Director: After this ō 28a. Date of Injury (Month, Day Year) 27. Manner of Deat 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the I within 2 29b. Signature and litle of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

STON AVE BALTIMOREMOS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

REED,

Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-02906 State of Maryland / Department of Health and Mental Hygiene Douglas L. Maxwell Certificate of Death Reg. No. 1. For State 2. Date of Death Registrar 1. Decedent's Name (First, Middle,Last) Month Day April 11, 2009 Physician/ 1536 hrs Lee Maxwell Douglass Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Frederick Frederick Frederick Memorial Hospital 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number dec 15,1938 Foreign Country) Min. **Funeral** Hours Months Days 70 535.38.3852 Director 1^X M 2 F Yrs Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 Yes 2 X No Frederick Frederick MD 23a or 28a-f show notified at once. Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
Iant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. 10g. Citizen of What Country Director 10f. Zip Code 10e, Street and Number USA 21703 5800 Genesis Lane 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral 11 Marital Status White, etc If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces' Never Married 2 Married White Yes Specify Yes 2 No specify: If Yes, Give Year 4 Divorced Widowed 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 2 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) US Government Elementary/Secondary (0-12) Economist 5+ 21215-0036 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charlotte_Catherine Maxwel| Be Milton Andrew Maxwell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) San Francisco, CA 94118 123 16th Ave. Ross R. Maxwell Brother Baltimore, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place)
I a M a I p i a S Removal from State |Marin Co., CA 4/24/09 Cem. 1 g Burial Cremation 3 Important: 1 injury or oth Other Specify 22. Name and Address of Facility Slack Funeral Home, ghature of Funeral Service License 387101d Columbia Pike, Ellicott City Approximate Interval sizease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and **Physician** failure. List only one cause on each line Death a. Hypertensive Atherosclerotic Cardiovascular Disease 1edical Immediate Cause (Final disease aminer Due to (or as a consequence of) or condition resulting in death) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Exami (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last andtran an/Medical **AMENDED** ysician a UNPENDED The law requires that the death certificate be 23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE the attending phy: ed for use as the b Day Year 3 Ectopic pregnancy Fetal death 23b. Was decedent pregnant in the past 12 months? Pregnant at time of death 5 Other (Specify) Physic 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records. P.O. Yes 2 ✔ No 3 Probably 4 Unknown þ Diabetes Mellitus; Dementia 24b. Were autopsy findings available 24a. Was an Completed prior to completion of cause of has been autopsy performed? death? Νo 1 🗸 Yes ✓ Yes 2 certificate 26.Place of Death (Check only one) 25. Was case referred to medical Hospital or Attending Physician: 24 hours after death Be Other₄ Residence 6 Nursing Home 5 Hospital: 1 Inpatient 2 V ER/Outpatient 3 this 1 🗸 Yes 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 27. Manner of Death After Certification: 1 Yes 2 No 1 V Natural Division filled in by the f 28f. Location (Street and Number or Rural Route Number, City 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) Could not be Suicide determined Funeral Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical To the | within 2 To the | one) and manner stated. 29d. Date signed (Month, Day, Year) 29c, License number 29b. Signature and title of certifier

State 31. Date filed (Month, Day, Year Registrar APR 24

Registrar's Signatur

ORIGINAL

O.C.M.E

111 Penn Street, Baltimore, MD 21201

April 12, 2009

Laron Locke MD.

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death ecedent's Name (First, Middle, Last) Day **Physician** /Medical 4c. County of Death 4a. Facility Name (If not institution, ity, Town, or Location of Death **Examiner** eld timore Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Hours Davs 1 □ M 2 5 F Months Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show injury or other traumatic event, the Medical Examiner must be notified at Director 1. Yes 2 No timore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ò effield 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 1 Tes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify. þ 3 Widowed 4 □ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than College (1-4or 5+) and Mental Hygie er's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ne 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship Department of Health ar Important: If item 27 is any injury or other trau 1030 20b. Place of Disposition (Name of cemetery, crematory or other place) od of Disposition Pages 1 Burial 2 Cremation 3 Removal from State □Donation 5 □Other (Specify) 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause of ach line. Approximate Interval Between Onset and Death such as cardiac or respiratory arrest Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed Due to (or as a consequence of) burial-1 anding physician use as the buria Physician/Medical attending properties for use as IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 1 ☐ Yes 2 No 9 ☐ Unknown 5 ☐ Other (specify) P.0. the à signed by be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 2 should Completed peen 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? certificate has page 2 No 1 □ Yes 2 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical director Be 26. Place of Death (Check only one, examiner? Other: 4 \sum Nursing Home 1∐Yes 2∭No 2 ER/Outpatient 3 DOA 1 ☐ Inpatient 5 Residence 6 ☐ Other (Specify) Certification: To After this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation **Natural** within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide determined 4 Hemicide Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier

State

State Registrar 31. Date

th Day Year) 32. Figistrar's Signature

and address of person who completed cause of death (Item 23a) (Type, Print)

2. Figistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

τ _	. تىر	1 - State Registrar 1. Decedent's Name (First, Middle, Las	State of Maryla		tment of F		Re 2. Date of Death	g. No. 2 U U	9 3 L	
Physici /Medi Examir	cal	4a. Facility Name (If not institution, give	e street and number) anyland Malice		4b. City, Town, or	Location of Death	N onth P	Day Yea 12 200 4c. County of De	9 1059	
Funeral Director		 Social Security Number 6. S 		s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Feb 20,	9. B Year) 9. B 1947 Ma	irthplace <i>(State or For</i> Cou <i>ntry)</i> ryland	
Hygiene. uther than "natural", or items 23a or 28a-f show ent, the Andical Everal ner must be matthed at	ector	10a. State 10b. County MD Baltime		Baltimo	re				10d. Inside City Lir 1 □ Yes 2√X	
23a or 2	Funeral Director	10e. Street and Number 12816 Cunninghil	l Cove Road		10f. Zip Code 212			g. Citizen of What (
f Health and Mental Hygiene. Item 27 Is marked other than "natural" or items 23a or 28a-f show other traumatic event, the "Medical Event net must be notified at		11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in I Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: 167-	41	as Decedent of H Yes, specify Cuba □Yes 2M∑No	ispanic Origin? (Spin, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black, Wh	nerican Indian, ite, etc. white	
ene. than "natu he Medical	Completed by	15. Decedent's Ed (Specify only highest graded) Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	(Give ki	ent's Usual Occup ind of work done of NOT use retired electric	during most of worki)	ng	6b. Kind of Busines	·	
and Mental Hygiene. Is marked other than aumatic event, the	To Be Co	17. Father's Name (First, Middle, Last) John Joseph Merk			<u> </u>		(First, Middle, M	state of MD		
Health and Niem 27 is mai		19a. Informant's Name/Relationship (al Route Number,	City or Town, State	, Zip Code)	
0		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 4 □ Donation 5 ▼ Other (Specify	Removal from State 7	Place of Disposi cemetery, crema	tion (Name of atory or other plac	e) (Date 2	Oc. Location - City of	or Town, State	
Department Important; I any injury o		21. Signature of Funeral Service Licen Ronale S 23a. Parl 1. Enter the disease, or comp	Wade, Directo	St Ba	500 h 50 h 50 h	omy Board MD 2120		Baltimore	Street	
nysician Medical xaminer		show, or heart failure. List only immediate the cycle (Final disease or condition resulting in death) Sequentially list conditions,	a	equence of):	,	ejection			Interval Betwee Onset and Dear	
hysician and the burial-transit	ical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conse							
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jo eg	<u>₹</u>	Part II. Other significant conditions of	ontributing to death but not re	esulting in the und	lerlying cause giv	en in Part I.			to the cause of deat	
cate has been s page 2 should	Completed						24a. Was an autopsy perform	/ prior t	autopsy findings ava o completion of caus ? es 2 \(\square\) No	
is certifi director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2	☐ ER/Outpatient	3 □ DOA Oth	26. Place of Deather: 4 ☐ Nursing Ho	-	nce 6 ☐ Other (S)	pecify)	
within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certification:	27. Manprer of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28b. Injury at Work? 1 Yes 2 No 28d. Describe how injury of Injury of Injury M 28d. Describe how injury of Injury at Work? 1 Yes 2 No 28d. Describe how injury of Injury of Injury at Work? 28d. Describe how injury of Injury at Work?							Rural Route Number,	
n 24 hours se Funeral stetely filled	Medical Co	29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exam	ysician: To the best of my kininer: On the basis of examined and manner stated.	nowledge, death nation and/or inve	occurred at the tilestigation, in my o	me, date and place, pinion, death occur	and due to the ca red at the time, da	ause(s) and manner ate and place, and d	as stated. ue to the cause(s)	
within То th сопр	Me	29b. Signature and title of certifier	my 1	MD	29c. Licens	52		od. Date signed (Mo		
		30. Name and address of person who Janathan Daining 31. Date filed (Month, Day, Year)	completed ause of death (the	em 23a) (Type, P	paltimere	MD 2	1230	,		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

enneth McCarthy		ment of Health and Mental Hy cate of Death	/giene 2009 1314						
Physician/ ledical Examine	Decedent's Name (First, Middle, Last) Kenneth McCarthy		2. Date of Death Month Day March 23, 2009 3. Time of Death 1240 hrs						
	Facility Name (if not institution, give street and number) 612 62nd Place	4b. City, Town, or Location of Death Seat Pleasant	4c. County of Death Prince George's						
Funeral Director	5. Social Security Number unk 6. Sex 7. Age (In yrs. last b	oirthday) If Under 1 Year If Under 24Hrs. Months Days Hours Min.	8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or unk Foreign Country)						
ом апу		vn or Location	10d. Inside City Limits 1 Yes 2 X No						
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nours after death with t natural", or items 23s <u>Examiner must be not</u>	11. Marital Status 1 Never Married 2 Married Armed Forces? Unk 3 Widowed 4 Divorced or Divorced or Dates:	13. Was Decedent of Hispanic Origin? (Spilf Yes, specify Cuban, Mexican, Puerto I 1 Yes 2 X No specify: a. Decedent's Usual Occupation (Give kind of working life. DO NOT use retired to the specific process of the specifi	White, etc. Specify: black ork doneink 16b. Kind of Business/Industry 11nk						
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Physician 'Medical kaminer	23a. Part I. Enter the disease or complications that caused the death. Do failute. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	not enter the mode of dyirig, such as cardiac or	Tespiratory arrest, shock, or heart Approximate Interval Between Onset and Death						
ecuted and transit	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): d.								
Box 68760, c death certificate be executed the attending physician and ed for use as the burial – transi Nysician/Medical E.	1 Ves 2 No.9 Unknown death	2 Fetal death 3 Ectopic pregnar 5 Other (Specify)	23d. Date of delivery Month Day Year						
Records, P.O. Bc The law requires that the det ficate has been signed by the a page 2 should be detached fo Completed by Phys		ing in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?						
of Vital Physician: er this certi ral director To Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/		1 V Yes 2 No 1 V Yes 2 No nly one) 9 Home 5 Residence 6 Other: Scene 28d. Describe how injury occurred						
Division o To the Hospital or Attending within 24 hours after death. To the Funeral Director: Aft completely filled in by the fune-	3 Suicide 6 Could not be determined (Specify) 29a. Certifier Coertifying Physician: To the best of my knowledge, or	death occurred at the time, date and place, and d							
To the Hos within 24 h To the Fur completely	29b. Signature and title of certifier 30-Name and address of person who completed cause of death (Item 23a Laron Locke MD. Assistant Medical Examiner 1	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) March 24, 2009						
State Registra	31. Date filed (Month, Day, Year) 37 Registrar's Signature	Sarls							
DHMH 17 Rev 1/2001		RIGINAL							

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Lawrence A. Novak, Jr pni /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sector, If Under 24 Hrs. rare 8. Date of Birth (Month, Day, Year) Tilly 25, 1929 7. Age (In vrs. last birthday) **Funeral** 5. Social Security Number 214-24-4072 Months Days XXM 2□ F 79 Yrs Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, Its Madical Expressions is be notified at MD Director Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9609 10th Avenue 21234 Funeral 12. Was Decedent Ever in U.S. Armed Forces? ★TYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married XX Married 1 □Yes 2 🗷 No ģ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Majestic Distilling Warehousman 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lawrence A. Novak, Sr ပ Marie S. Palcher 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Department of Health a Important: If item 27 is any injury or other trau once. Ellen B. Novak-spose 9609 10th Avenue-Parkville, Maryland 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Cardens Of Faith Cemetery Apr. 25, 2009 Rosedale, Maryland XI Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 8800 Harford Road F.VANS FUNERAL CHAPEL AND CREATTION SERVICES Parkville, MD 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last tending physician are use as the burial-Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 5 ☐ Other (specify) signed by the a 1 ☐Yes 2 ☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ₽ Completed 24a. Was an autopsy certificate 1 □Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No Hospital: မ 1 Nnpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After thi 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 🕅 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Director: 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certif 29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

Registrar

30. Name and address of person

31. Date filed (Month, Day, Year)

Kirsten Hogan

ORIGINAL

23e. Did tobacco use contribute to the cause of death?

Day

Year

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown

23d. Date of delivery

Month

Year

2009

USA

Specify:

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 ☐ Yes X ☐ No

Maryland

Race - American Indian, Black, White, etc.

white

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐Yes 2 ☐No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

22/09

9000 M.D. Pegistrar's Signature

M.D. who completed cause of death (Item 23a) (Type, Print)

		For State Registrar
Physic /Medi		1. Decedent's l
Exami		4a. Facility Nar
Funeral		5. Social Secur
Director		218.
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Haryland 2 should be file and Mental Hy is marked oth	2	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Marical Evaluation must be notified at once.	i.	19a. Informan John C
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√ Division of Vital Records, P.O. Box 68760,

/Medical	ı	Decedent's Name (se Noonan		2. Date of Death Month Day Year Apr 18, 2009 3. Time of Death				
Examiner		4a. Facility Name (If n		street and number)		4b. City, Town, o	r Location of Death	1	4c. County		
uneral irector		5. Social Security Num 218.14.38 Usual Residence of D	878	ex 7. Ag □M 2MPF	ge (In yrs. last birthday, 84 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da Nov	h y, Year) 15, 1924	9. Birthplace (Sta Country)	MD
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al", or items		11. Marital Status 1 Never Married 3 Widowed 4		12. Was Decedent Armed Forces? 1 \(\subseteq Yes \) 2 \(\subseteq If Yes \), Give Year or Dates:	No	Was Decedent of H If Yes, specify Cuba 1 □Yes 2 No	Hispanic Origin? (S) an, Mexican, Puerto Specify:	pecify Yes or No De Rican, etc.)		e - American Indian k, White, etc. White	,
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it to "hodical Evaluinar must be notified at once. To Be Completed by Funeral Director	-		5. Decedent's Ed y only highest grad dary (0-12)		(Give	Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) office worker			16b. Kind of Business/Industry Social Security		/
arked other atic event, I	3	17. Father's Name (Fi		ohn Carroll R	Rehmert	18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Jeannete Hahn					
n 27 is m ier traum		19a. Informant's Nam John Carro	ne/Relationship (1		111	ng Address (Street 1 Font Hill D				State, Zip Code)	
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sician edical		2 a. Part 1. Enter the shock, or heart mmediate Cause (Fi disease or condition resulting in death)	failure. List only of	a. ALZ	d the death. Do not enne. HEIMER a consequence of):	1			rest,	Approxin Interval I Onset ar	Between nd Death
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36	be filed within 72 hours after death with the Maryland rtal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Madical Exemirer must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☒ Mai	rried 1 1	s Decedent ned Forces? ¶Yes 2 ☐ I ēs, Give	No		Was Deced If Yes, sped 1 □Yes :		ispanic Ori n, Mexicar Specify:		cify Yes or N Rican, etc.)	lo-	14. Race - Black, \ Specify:			
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Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trai once.		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 4 ☐ Donation 5 ☐ Other (S	3 □ Remova Specify)	from State	Moi Cre	lace of Dispo emetery, cren ntgome emator	sition (Nam natory or o Y 111m -	ne of ther place Tnc.	<i>^{e)}</i> А	pri1 2009			ocation - Cit hesda •		_{vn, State} ryland	
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d	Physician /Medical Examiner		23a Fart 1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	t only one caus	e on each li	ne. nic O	bstruc						arrest,			Approximate Intervat Betw Onset and D	reen
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P.O. Box 68	or Attending Physician: The law requires that the death certificate be itter death. Director: After this certificate has been signed by the attending physicic in by the funeral director, page 2 should be detached for use as the bu	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 <u>-</u> 4 <u>-</u>	es, outcome] Live birth] Pregnant a] Unknown	2 Fetal	death 3 [Ectopic p		,	A!			23d. Date o Month		,	ear
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0	ding Ph n. After th funeral	L:	27. Manner of Death 1 X Natural 5 ☐ Pendii	28a.	Date of Inju	ıry y, Year)	28b. Time of Injury	2	8c. Injury Work			8d. Describe					
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	oll			7					D006	4624			Apr	il 20,	20	09	
	10+1		30. Name and address of person Sandeep Sharma	, M.D.,	1090	1 Cor	nectio	,	ve.,	Kens	ingto	on, Ma	ryla	nd 208	395		
	Sta Registr		31. Date filed (Month, Day, Year) APR 2 4	2009	Registr	ar's Signat	. fac	Mark									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death
 Month **Physician** Day Year DELORES ELAINE NAYLOR APRIL /Medical 2009 3:00P 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death Examiner 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗹 F Months Days Hours Min 214-34-030 **Director** mo. une 19,1936 Usual Residence of Deceden 10a, State show 10b. County 10c. City, Town or Location 10d. Inside City Limits d 2 should be filed within 72 hours after death with the Marylai thin and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, it a Medical Examination and the profiled at FREDERICK mo. 1 ✓ Yes 2 ☐ No Director PREDERICR 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? WILLOWOALE DR. APT 11 USA 21702 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No à 3 ☑ Widowed 4 ☐ Divorced Specify: BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) ALR PAK Elementary/Secondary (0-12) College (1-4or 5+) 9556MBL 12 TH GV. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be JENKINS ဂ္ ROBERT DIGGS NETTIE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 and Department of Health an Important: If item 27 is any injury or other trau WAYNE NAYLOR SON CANADA GOOSE CT. FREDERICK MO 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State PAUL AME CH. APR 27, 2009 DICKERSON, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CARY L. ROLLINS FULL I TOME Collis neu 110 WEST SOUTH ST FREDERICK MD 21101 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Myo cardia **Physician** archon disease or condition resulting in death) In Mimite /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a conse jueno, of) attending physician and for use as the burial-trans Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day 5 ☐ Other (specify) i signed by the a d be detached f 1 ☐ Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? page 2 s 2 □ No 1 □ Yes 2 🗖 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Matural 2 Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

The law requires that the death certificate be executed P.0. of Vital Records, or Attending Physician: Division

3altimore, Maryland 21215-0036

After this certificate within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral To the Hospital

State

Registrar

Medical

29a, Certifier

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD Caidi Jaeed

32. Registrar's S

801

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number D43091

Tou House Ave.

29d. Date signed (Month, Day, Year)

4-21-09

Brederick MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day 2009^{ear} APRTL **JEFFREY ORBACH** 21 11:08 A M HUGO GLENN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SHADY GROVE ADVENTIST HOSPITAL MONTGOMERY ROCKVILLE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 02/02/1961 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1 X M 2 □ F 214-84-8031 48 DC Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d Inside City Limits 28a-f show 7 Is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Mudical Eventhan must be muitified as 1 ☐ Yes 2 🔀 No Director MD MONTGOMERY DERWOOD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 1 and 10 fleatilth and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 1 and 10 fleatilth and 10 f 7212 SUGAR MAPLE COURT 20855 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 ☐ Never Married 2 X Married Saltimore, Maryland 21215-0036 1 ☐Yes 2 X No Specify. Specify: WHITE Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) DENTIST DENTAL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **GUNTHER** ORBACH PAULA SINGER ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROSANE C. ORBACH / WIFE 7212 SUGAR MAPLE CT., DERWOOD, MD 20b. Place of Disposition (Name of OHEB ALCOMY or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If it any Injury or o 1 N Burial 2 □ Cremation 3 □ Removal from State MEMORIAL PARK 04/23/2009 REISTERSTOWN, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licencee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. <u>8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</u> Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** MULTIORGAN FAILURE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner METASTATIC SMALL BOWEL ADENOCARCINOMA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transi Exami Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ⋧ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a Was an autopsy performed? 1 □ Yes 2 🗓 No certificate the Hospital or Attending Physician: hin 24 hours after death. the Funeral Director: After this certifica funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To . Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral D 1 % Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier April 21, 2009 Madrail 1000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical Center Drive, Rockville, Md., 20850 Hubbl - 9901 31. Date filed (Month, Day, 32. Registrar's Signature Year) State Registrar

Franceska Obom	niahi	e State of Maryland / Department of Health and Mental H		Die.	
· ranocona Ozon	Ŭ.	- For State Certificate of Death	Reg.	No. 200	9 1314
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of Death		3. Time of Death
Medical Examin	ner	-ranceska Obomighie	Month E April 21, 200		2016 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Good Samaritan Hospital Baltimore	1	4c. County of Deat	1
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs	8. Date of Birth	MM/DD/YYYY) 9. Bis	
Director		720-86-0900 1 M 2XF 43 Yrs. Months Days Hours Min	6-24-	1965 Forei	ountry) MD
	ŀ	Usual Residence of Decedent	1021	1100	
w any		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 es 2 No
Maryland 28a-f show	ţ	MD Baltimore		. Citizen of What Cou	
e Mary or 28a	Director	100. Street and Number 100. Ct. Co. mo. con. Dow.d. 21.2-1.2-1	TOG	. Citizen of What Cot	mury?
r death with the Maryland or items 23s or 28s-f sho must be notified at once.	<u>a</u>	11. Mantal Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S.	pecify Yes or No-	14. Race - Ame	rican Indian, Black,
leath v	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto		White, etc.	1 10
after call, on	by F	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:		Specify: J	lack.
hours natur Exami	eted k	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use ret		6b. Kind of Business.	/Industry
36 iin 72 s. than "dic.l."	Bet	College (1-4 or 5+) 2 Gears ASSOC: Avalus +		D.H.1	м · H -
5-0036 lled within 7 Hygiene. I other than	Comple		e (First, Middle, Ma	iden Surname)	• • •
24 be fi rked rked	Be	Wade To land Bern	ette	Harris	5
D 21 should and Me 7 is ma	5	19a. Informant's Name/Relationship (Type, Print) (Moffler) 19b. Mailing Address (Street and Number or	Rural Route Numb	er, City or Town, Stat	e, Zip Code)
, MI and 2 : eatth a em 27	1	20a, Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date	20c. Location - City o	r Town, State
more, MD 2 Pages I and 2 shou tent of Health and N ant: If item 27 is n		1 Burial 2 Cremation 3 Removal from State crematory or other place)	nolon	Dald	CIL
Baltime permit. Pag Department Important: injury or of		4 Donation 5 Other Specify: M	20/20	1 200	50 00 100 W
Balti permit. Departm Imports injury o		MALSS3 Voughu Carre	DO - BO	Ido MD	2/212
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dyin, such as cardiac failure. List only one cause on each line.	or respiratory arres	t, shock, or heart	Approximate Interval Between Onset and
/Medical / xaminer		Immediate Cause (Final disease a. Smoke and Spot Inhalation			Death
		or condition resulting in death) Due to (or as a consequence of):			
	Jer	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
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executed an and al - transit		d.			
ज ज ह	an/Medical	UNPENDED AMENDED			
Box 68760, e death certificate be exe the attending physician ed for use as the burial.	/Me	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy	ancy	23d. Date of delive	ry Day Year
K 68 1 certif ending use as	iciar	past 12 months? 4 Pregnant at time of death 5 Other (Specify)	iancy	Worth	Day Tea
Bo) e deat	hysi	1 Yes 2 No 9 V Unknown 9 Unknown			
P.O.	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			o the cause of death?
S, F quires en sign uld be			24a. Was a		autopsy findings available
SOFC law re has be	ompleted		autops perform	y prior to	completion of cause of
Re(The ficate	Con		1 Yes 2	✓ No 1	Yes 2 No
Division of Vital Records, P.O. Box 68760, within 24 hours after death certificate be within 24 hours after death. To the Function: After this certificate has been signed by the attending physici completely filled in by the funeral direction, page 2 should be detached for use as the buri	Be	25. Was case referred to medical examiner? 26. Place of Death (Check examiner? Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3 DOA Other Nurs		Residence 6 Oth	er:
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VISI or Att fter de Direct in by	ifica	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (St or Town, St		Rural Route Number, City
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Cert	4 Homicide determined (Specify) Residence	1004 Cameron	Road, Baltimore,	MD
To the Hos within 24 h To the Fur		29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred	nd due to the cause at the time, date a	(s) and manner as st nd place, and due to	ated. the cause(s)
To 11 withi To 11	Medical	29b. Signature and title of certifier 29c. License number		29d. Date signed (N	
	-	O.C.M.E.		April 22, 2009	
, V		30. Name and address of person who completed cause of death (Item 23a)			
14		Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimo	ore, MD 21201		
S	tate	31. Date filed (Man Pry 294 2009 32 Jegistrar's Signature Lives Samuel	-		

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 201015 9:000 **Physician** Deborah Madeline Powell /Medical 4b. City, Town, or Location of Death 4c. County of Death. 4a. Facility Name (If not institution, give street and number) Examiner Center Towson Saint Joseph Medical If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Y 12/17/47 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 ☐ M 2 🕱 F 61 212-50-1004 Maryland Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show 7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examirer must be redfled at 1 ☐ Yes 2 🔀 No Director Cockeysville MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with U.S.A. 21030 413 B Lake Vista Circle Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 and 2 should be filed within 72 hours after 1 ∐Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 Specify: White 1 ☐Yes 2 No þ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Healthcare Nurse 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Madlin M. Milanicz ည Earle Francis O'Connor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 Is
any injury or other trau 413 B Lake Vista Circle, Cockeysville, MD 21030 Michael Powell 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/22/2009 Hanover, Maryland Anatamy Gifts Regisrty 4 ☑ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Funeral Service License 7522 Connelley Dr., Ste.P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** SEPTIC SHOCK disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** PNEUMONIA Sequentially list conditions Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending PhysIclan: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical the attending ph for use as th IF FEMALE yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 mon Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ CLOSTRIDIUM DIFFICILE COLITIS 2 No 3 Probably 4 Unknown 1 🗌 Yes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier -15-0a D30263 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

OSLER

7601

DRIVE TOWSON.

MARYLAND 21204

Physician /Medical Examiner

Department of Health ar Important: If item 27 Is any Injury or other trauonce.

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

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Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Examine physician and s the burial-tran Physician/Medical attending for use as þ Completed Be this c ဥ Medical Certification: Director:

the Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

IF FEMALE 23b. Was decedent pregnant

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 ☐ Yes No

27. Manner of Death Natural 2 Accident 5 ☐ Pending investigation 6 ☐ Could not be 3 Suicide

28a. Date of Injury (Month, Day Year) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and titl

determined

29d. Date signed (Month, Day, Year)

State Registrar

within 24 hours aff

To the Funeral D

completely filled in

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 3:00 AM M Charles Paul 2009 April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Vantage House Columbia Howard 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yea Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 X M 2 □ F 158-01-0299 New Jersey 92 July 10, Director 1916 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 'natural", or items 23a or 28a-f shov dical Examiner must be notifled at MD 1 ☐ Yes 2√2 No Director Howard Columbia 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 5400 Vantage Point Road #704 Funeral 21044 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Amed Forces: 1 X) Yes 2 □ No If Yes, Give Year or Dates: 41-45 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 💢 No white þ 3 ☐ Widowed 4 ☐ Divorced Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) 12 retail sales hardware h and Mental Hygie 7 Is marked other t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Morris Paul Rose Kaufman 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 siment of Health an Gertrude Paul/spouse 5400 Vantage House Road #704 Columbia MD 21044 re of Disposition (Name of Date Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages: Department of H Important: If ite any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Came (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): the burial-ल as

Physician /Medical Examiner

within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

should be

and physician attending p for use as signed by the a d be detached f has e 2 page certificate

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: After within 24 hours after death.

To the Funeral Director; A completely filled in by the fu

> State Registrar

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

Courtio

APR 24 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

픙		- u.					_	
hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome pf pregr 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3 □Ectopic p			23d. Date of delivery Month Day Year		
ed by Pr	Part II. Other significant conditions	contributing to death but not res	sulting in the underlying of	cause given in Part I.		o use contribute to the cause of death? 2 No 3 Probably 4 Unknow	/n	
Complet				0	24a. Was an autopsy performed?		le	
ø	25. Was case referred to medical			26. Place of Dea	ath (Check only one)		_	
0	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 □ D	Othor		6 ☐Other (Specify)		
cation:	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigati	28a. Date of Injury (Month, Day Year) on	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how inj	iury occurred		
Certifica	3 Suicide 6 Could not 4 Homicide determine	28e. Place of injury - At r	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Str. City or Town					
cal	29a. Certifier 1 CertifyIng I	Physician: To the best of my kn aminer: On the basis of examin	owledge, death occurred ation and/or investigation	at the time, date and place n, in my opinion, death occ	e, and due to the cause(urred at the time, date a	(s) and manner as stated. and place, and due to the cause(s)		

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Examend Item 25 perate of Mary 1024/29 709 time 281 Health and Mental Hygiene 2 0 0 9 State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 01, 2009 P.M April 7:24 Shirley Ruth Pomeroy /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Gilchrist Hospice TOWSOT1

If Under 1 Year | If Under 24 Hrs. Baltimore County Birthplace (State or Foreign Country) 7. Age (In yrs. last birthdav) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex **Funeral** Months Days Hours 1 □ M 2 🖾 F Yrs. Baltimore, MD June 03,1927 Director 216-24-8999 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Evan in manual or mailified at 1 ☐ Yes 2 ☑ No Maryland Baltimore County Parkville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2217F Lowells Glen Road 21234 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐Yes 2X No 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates 1 ∐Yes 2 🗹 ¥No Specify: White Specify: 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) N/A Elementary/Secondary (0-12) Home Maker Own Home d 2 should be filed with and Mental Hygier 7 is marked other the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ida Rehberger John George Miller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 sment of Health an ant: If item 27 is ury or other traus Apt.9E New York, New York 10024 562 West End Ave. Mr. Dale M. Pomeroy (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o 1 ☐ Burial 2 ☐ €remation 3 ☐ Removal from State April 02, Evans Funeral Chapel 4 ☐ Donation 5 ☐ Other (Specify) 2009 Forest Hill, Maryland 22. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation Ctr., P.A.
2325 York Road Timonium, Maryland 21093 23a. Part 1. Inter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death vemerhasic **Physician** disease or condition resulting in death) TON APPROVED BY MEDICAL EXAMINE /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) burial-transi resulting in death) Last Due to (or as a consequence of): CERTIFIC physician the burial Physician/Medical as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? signed by the atte Month 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 nknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 No 1 ☐ Yes 2 ☐ No 1 □ Yes sspital or Attending Physician: 1 hours after death. uneral Director: After this certifically filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Waspie 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred 5 Pending investigation UNWINESSED MARCH 29 200 WEINNAM 1 ☐ Yes 2 Accider 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 2217 To the Hospital within 24 hours a To the Funeral C completely filled in the Funeral C completely filled in the fil 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier April 2

State Registrar

Maryland 21215-0036

Baltimore,

of Vital Records,

Division

APR 2 3 2009

AARUN

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

COTAMER



NO 6701 N. Charles

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Day Month **Physician** 11:00A^M LEE REDMOND, SR 2009 GILBERT /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE COURT 1601 BALMOR If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye JUNE 18, 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Year Months 1 **X**M 2 □ F 1948 MD 60 Director 218-44-8644 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County ns 23a or 28a-f show X□Yes 2 □ No **Funeral Director** BALTIMORE MD 10g. Citizen of What Country? 10e Street and Number 10f. Zin Code USA 21217 1601 BALMOR CT. ral", or items 2 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Yo Specify: þ 3 Widowed 4 Divorced BLACK "natural". Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h. Kind of Business/Industry the Medical Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. MACHINE OPERATOR ONTINENTAL CAN CO. 11 7 is marked other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be fi and Mental F JOYCE E. DOWELL MILTON LEROY REDMOND ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1601 BALMOR CT., BALTIMORE, MD 21217 Pages 1 and 2 f of Health PENNY HOPKINS, FIANCE item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Department of Important: If it any injury or conce. Burial 2 Cremation 3 Removal from State MT. ZION 04-28-09 BALTIMORE, MD 4 Donation 5 Dother (Specify) 21. Sign of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC 1701 LAURENS ST., BALTIMORE, MD 21217 Part 1. Enter the disease, or complications that caus d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical the attending pl IF FEMALE yes, outcome of pregnancy

□ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 ☐ Other (specify) ed by the a Ö 9 Unknown s been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has N autopsy performe page certificate 1 ☐ Yes 2 No 1 ☐ Yes Division of Vital Physician: 25. Was case referre o medical examiner? 26. Place of Death (Check only gne) Be Other: 4 Nursing Home 5 Residence 6 □ Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28b. Time of Injury 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After 1 To the Hospital or Attending 1 Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu investigation 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only within 2 To the F and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 00011 30. Name and address of person, who completed cause of death (Item 23a) (Type

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

283

32. Registrar's Signatur

BALTO MI) 2126

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 9 1 - State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Apri **Physician** JEAN ROLLINS CATHERINE /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** FREDERICK FREDERICK BIRMINGHAM 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 2以F Months Days Hours 5 233-68-408 MISSISSIPPI Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show d other than "natural", or Items 23a or 28a-f shorevent, the Madical Evantiner must be notified at MD FREDERICK FREDERICK Funeral Director 1 ☑Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with to Department of Health and Mental Hygiene. Important: If frem 27 is marked other than "natural", or Items 22a any Injury or other traumatic event. The Market State of Once. BIRMINGHAM DR 21701 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify ۾ Specify: BLACK 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) CARROLL CTY Elementary/Secondary (0-12) SCH BOARD SCHOOL TEACHER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be IVORY BLACKMON IDA SAMFORD ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOHN ROLLINS HUSBAND) 424 BIRMINGHAM DR FREDERICK MO 21701 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State SUNNYSIDE UMCCOM, ARRIL 27, RODG FRED. MD. 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licental 22. Name and Address of Facility GARY L. ROLLINS FUN. HOME Sary X. 110 WEST SOUTH ST FREDERICK MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) METASTATIC ENDOMETRIAL CANCER **Physician** YEARS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence of a Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Ye ar Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s autopsy 1 □Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 031761 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BRIAN M. O'COANOR 501 W. SEVENTH ST. FRESERICK MD 21701 MD 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

APR 24 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For Amend #8 per Fh G 891 5/15/09 Tilment of Health and Mental Hygiene Certificate of Death

Reg. No. 2 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) :19PM Year **Physician** RICIA 23 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Trunder 1 Year | Trunder 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 3 (Month, Day, Year) U MUERSITY OF MARYLAND MEDICAL CONTER 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1 □ M 2X F 68 05/05/1941 220-36-9460 Baltimore, MD Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show other traumatic event, it is Medical Examiner must be notified at 1 ☐ Yes 2 No Baltimore Parkville Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number and 2 should be filed within 72 hours after death with 'teath and Mental Hygiene. m 27 Is marked other than "natural", or items 23a or 21234 8525 Willow Oak Road U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: ≥ Specify: White 3X Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Konica Business Machines Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mildred Holl Edward Garrettson ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9104 Deviation Road, Nottingham, MD 21236 Lori Stylc/ Daughter Health tem 27 l parmit. Pages 1 and Department of Healt Important: If Item 2 any Injury or other once. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State :04/29/09 Parkville, MD Parkwood Cemetery 4 Donation 5 Dother (Specify) 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services
8800 Hardord Rd. Parkville, MD 21234 ture of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ate Cause (Final SUBARKU NOIS **Physician** NEWWERNAGE e or condition ng in death) /Medical Due to (or as a consequence of): Examiner BLEENING Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner I or Attending Physician: The law requires that the death certificate be executed after death. resulting in death) Last Due to (or as a consequence of): Box 68760, Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 Other (specify) 1 ☐ Yes 2 ☐No P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, 1 √Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No certificate 2 No 1 Yes neral Director; After this certific filled in by tha funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1. Inpatient Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death

1 2 Natural

2 Accident 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Division 5 Pending investigation 1 ☐Yes 2 ☐ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) and address of person who completed cause of death (Item 23a) (Type, Print) 27. SOUTH GREENE ZBAUER

Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Registrar's Signature

OCHUNG

31. Date filed (Month, Day, Year)

ddie Shaw	State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No.	2009 1315
Physician/ ledical Examiner	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day	3. Time of Death Year 1633 hrs
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. Co	ounty of Death N/A
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD.	YYYYY) 9. Birthplace (State or Foreign
Director	212-44-2110 1XM 2 F 64 Yrs. Months Days Hours Min. Nov.12,19	
v any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
the Maryland a or 28a-f show lifted at once. Director	MD N/A Baltimore 106. Street and Number 109. Citizen	1 X Yes 2 No of What Country?
h the Ma 23a or 23 191ified		USA
death with r items 23 rust be no uneral	11. Marital Status 1 Never Married 2 Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? XX Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.)	. Race - American Indian, Black, White, etc.
ural", or	3 X Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specific Control of Dates: 16 No. 16	ecify: Black d of Business/Industry
n 72 hou an "nati ical Exa	Elementary/Secondary (0-12) College (1-4 or 5+) Detailer Gen.	eral Motors
5-0036 lied within 72 hour Hygiene. I other than "natu the Medical Exp	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Su	rname)
ID 21215-00; should be filed within and Mental Hygiene. 7 is marked other thatie event, the Med To Be Comp	Amos Shaw Carrie Lee Beth	
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Exminer must be notified at once To Be Completed by Funeral Director	Tony Shaw/ Nephew 3120 Gwynns Falls Pkwy Balt	· · · · · · · · · · · · · · · · · · ·
nore, MD ages 1 and 2 sh ant of Health an it: If item 27 is other trauma	1 X Burial 2 Cremation 3 Removal from State crematory or other place) 4/2//09 Carrison Forest Vet Cem	ngs Mills, MD
Baltimore, permit. Pages 1 ar Department of He. Important: If ite injury or other tr	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Chatman-Harr	is Funeral Home
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock	
/Medical xaminer	failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a, Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):	Death
	Sequentially list conditions,	
red red Examiner	if any, leading to immediate Cause. Enter Underlying Cause (C.) Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of):	
and transit		
60, ate be ex hysician e burial -	UNPENDED AMENDED AMENDED 23d. If yes, outcome of pregnancy 23d. If	Date of delivery
Box 6876 The death certificate the attending phy ned for use as the thy sician/M	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy M Pregnant at time of death 5 Other (Specify)	onth Day Year
Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and tely filler in y the funeral director, page 2 should be detached for use as the burial - transi al Certification: To Be Completed by Physician/Medical Ex	1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco us	e contribute to the cause of death?
ires that signed by be detailed by	Chronic alcohol abuse	No 3 Probably 4 V Unknown
Records, The law require: ficate has been sig. page 2 should be Completed	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
tal Rection: The certificate ector, page		1 Yes 2 No
of Vital Physician er this cert rad directo	1 Ves 2 No 1 Inpatient 2 EN Outpatient 3 DUA 4 Nursing Frome 5 Residence 27 Manner of Death 28a Date of Injury 28h Time of Injury 28c Injury at Work? 28d Describe how injury	
ion of tending Pleath. Tor: After the funera	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No	
Division os spiral or Attending nours after death. neral Director: After filler in sy the func Certification:	3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 28f. Location (Street and or Town, State)	Number or Rural Route Number, City
Divisor To the Hospital or A within 24 hours after To the Funeral Director Completely filler in Fedical Certific		manner as stated.
To the Ho within 24 To the Fu complete!	29b. Signature and title of certifier 29c. License number 29d. Da	ate signed (Month, Day, Year)
	(fillllll)	22, 2009
3	30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State	e 31. Date filed Wmith 2at Y2009 32. Registrar's Signature	

09-03070 Kevin Sellner

evin Sellner	State of Maryland / Department of I 1- For State Certificate of I	-lealth and Mental Hy! Death	giene Reg. No.	2009 13158
Physician/	Registrar 1. Decedent's Name (First, Middle,Last)		2. Date of Death Month Day April 17, 2009	3. Time of Death Year 0935 hrs
ledical Examiner		o. City, Town, or Location of Death		unty of Death
	4a. Facility Name (if not institution, give street and number) 4b 6305 Fernbank Avenue	Baltimore		
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 213-52-6917 1X M 2 F 45 Yrs.			9. Birthplace (State or Foreign Maryland Country)
	Usual Residence of Decedent 10a State 10b County 10c City, Town or Locatio	en .		10d. Inside City Limits
l tow any	MD Baltimore			1 XYes 2 No
he Maryland tor 28a-f show iffed at once. Director	10e. Street and Number	10f. Zip Code	10g. Citizen	of What Country?
3a or 2		21214 Decedent of Hispanic Origin? (Spe		Race - American Indian, Black,
leath with ritems 23 rust be no	11. Marital Status 1 X Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No	es, specify Cuban, Mexican, Puerto		White, etc.
fler des	3 Widowed 4 Divorced If Yes, Give Year 1	Yes 2 X No specify:		ecify: White
hours aft natural' Examine		's Usual Occupation (Give kind of working life. DO NOT use retire	red)	
5-0036 ed within 72 hour lygiene. other than "nature Medical Exan	Elementary/Secondary (0-12) College (1-4 or 5+) 1 2 Mainte			ock Church
			e (First, Middle, Maiden Sul Barranco	rname)
2121! ould be fill Mental Its smarked iic event,		Address (Street and Number or F		or Town, State, Zip Code)
MD 2 shou alth and h a 27 is r	Doris Sellner/ Mother 2506 (Comstalk Road, Fin	ksburg, MD	2104 8 cation - City or Town, State
ore, sslan of Hea If ite	20a. Method of Disposition 20b. Place of Disposition 20c. Place of Dispos	ition (Name of cemetery, ner place) eral Chape 1 04/2		rest Hill, MD
Baltimo permit. Page Department Important: injury or ot	21. Signature of Funeral Service Licensee 22. N	lame and Address of Facility ans Funera I Chapel	& Cremation	n Services
	23a Part Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line.	00 Harford Rd. Park ne mode of dying, such as cardiac	or respiratory arrest, shock	, or heart Approximate Interval Between Onset and
Physician Magical aminer	failure. List of ly one cause on each line. Immediate Cau e (Final disease or condition resulting in death) Due to (or as a consequence of):	on		Death
	Sequentially list conditions, b			
70 m in	if any, leading to immediate cause. Enter Undarrying Cause (Disease or injury that initiated events resulting in death) Last			
n and	X UNPENDED AMENDED 23a,27,28a-f,	perME, g891 5/21	709 TT	
760, cate be physici	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 2 Fe	etal death 3 Ectopic pregn		Date of delivery Month Day Year
Records, P.O. Box 68760, The law requires that the death certificate be e cate has been signed by the attending physician page 2 should be detached for use as the burial	nast 12 months?	etal death 3 Ectopic pregn ther (Specify)		
O. B at the d 1 by the tached		underlying cause given in Part I.		se contribute to the cause of death? No 3 Probably 4 Unknown
Pivision of Vital Records, P.O. Ital or Attending Physician: The law requires that the ras after death. rat Director: After this certificate has been signed by lited in by the funeral director, page 2 should be detach	pa		24a. Was an	24b. Were autopsy findings available
aw req	Completed		autopsy performed?	prior to completion of cause of death? 1 Ves 2 No
Rec: The I		26.Place of Death (Chec		100 2
/ital	So was case referred to inedical examiner? Hospital: 1 Inpatient 2 ER/Outpatier			ice 6 Other: Scene
ing Phy	27 Manner of Death 28a, Date of Injury 28b, Time of	1 Ves 2 X No	28d. Describe how injur	ry occurred
ision of Vital Attending Physician: r death. retor: After this certif by the funeral director.	Natural 5 Pending Investigation Fd 4/17/09 Fd 9: 28e. Place of Injury - At home, farm, str.	15 am	28f. Location (Street ar	Number of Rural Route Number, City 305 Fernbank Ave
Divi	Suicide Succide determined (Specify) hosue		Baitimore,	HD
Co la si	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occ one) 2 Medical Examiner: On the basis of examination and/or investig and manner stated. 29b. Signature and title of certifier	ation, in my opinion, death occurred	d at the time, date and place	ce, and due to the oddseto/
To To COUL	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
	they price the You'll	O.C.M.E.		
ek	I Wardanta Noron William	Penn Street, Baltimore, MI	D 21201	
Sta	ate 31. Date filed Month Daniel 2010 32. Registrar Signatural	,		
Regist	TELL METRICAL PARTY AND THE PA			

Elizabeth Ann S		1- For State	tate of Maryl		oartment of e <i>rtificate o</i>		nd Mental		00 No. 2 f	109 1315
Physici		Registrar 1. Decedent's Name (First, Mid-	dle,Last)					2. Date of Dea		3. Time of Death
Medical Exami		Elizabeth	A. SI	kiratko				Month April 21,	Day Year 2009	1530 hrs
		4a. Facility Name (if not institut	_	umber)		4b. City, Town, o		ath	4c. County of	
		7983 Nolpark Court,		I = 1 = 0 = ==	I and to be desired as a large	Glen Burni		In R Date of B	Anne Aru	Birthplace (State or
Funeral Director		5. Social Security Number	6. Sex	7. Age (in yrs	s. last birthday)	If Under 1 Ye Months Da		⁄lın.		Foreign
Director		220-82-9584	1 M 2X F	<u></u>	45 Yrs	i.		05/2	3/1963	Country) MD
any		Usual Residence of Decedent 10a. State 10b. County	у	10c. C	ity, Town or Locat	ion				10d. Inside City Limits
A	_	Maryland Ann	e Arundel			G1	en Burn	ie		1 Yes 2 X No
arylar 8a-f s at on	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of Wha	at Country?
the M a or 2	Dire	7983 Nolpark	Court #2	02			21061		U	SA
r death with the Maryland or items 23a or 28a-f show must be notified at once,	ıral	11. Marital Status		ecedent Ever in				Specify Yes or N		American Indian, Black,
death or ite	Funeral	1 Never Married 2	1 Yes	2 X No		es, specify Cuba	an, mexican, Pue	rto Rican, etc.)	White,	etc.
s after ral",	by F		ivorced If Yes, Give Ye or Dates:		1				Specify:	White
hour matii		 Decedent's Education (Sp Elementary/Secondary (0-12 		(1-4 or 5+)		nt's Usual Occupa nost of working lif			16b. Kind of Bus	iness/industry
36 hin 72 e. than	ple	12	4		Assi	stant Li	brarian		Anne A	rundel County
5-0036 led within 7 Hygiene. other than the Medica	Completed	17. Father's Name (First, Middl			1.001				, Maiden Surname)	runder country_
21215 vuld be file Mental H marked (c	Be (William M	. Mora	n			Marga	rita :	E. Ritt	
21 hould hould Me is man	ု	19a. Informant's Name/Relation							umber, City or Town	
MD nd 2 sho alth and m 27 is		Margarita E.	Moran (me	other)					a, MD 211	
ore, slar of Heg If ite		20a. Method of Disposition 1 X Burial 2 Crematic	on 3 Removal		 b. Place of Disposition crematory or of 		emetery, A	Date pril 27	20c. Location -	City or Town, State
imc Pagement ment or ot		4 Donation 5 Other	Specify:		edar Hil			2009		re, Maryland
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Maryland Homerand of Health and Maryland Hygoren Homerand is fire an in anaked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once		21. Signature of Funeral Service	e Lidensee		22.	Name and Addre				1 Home, P.A.
Physician		23a. Part I. Enter the disease,	or complications that	caused the de	ath. Do not enter				sadena, M	
/Medical caminer	- 3	failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	se on each line. se a. Multiple In	ijuries						Between Onset and Death
			Due to (or as	a consequenc	e of):					
	je.	Sequentially list conditions, if any, leading to immediate		a consequenc	e of):					
1	Examiner		events resulting in death) Last Due to (or as a consequence of):							
executed an and al - transit		d.								
D, be execut sician and	edical	UNPENDED	AMENDED)						
760 cate b physic		IF FEMALE:	tho	, outcome of p	regnancy				23d. Date of	
Records, P.O. Box 68760. The law requires that the death certificate care has been signed by the artending physpage 2 should be detached for use as the b	ician/M	23b. Was decedent pregnant in past 12 months?	LIVE	birth nant at time of	(etal death 3	Ectopic pre	gnancy	Month	Day Year
Box e death c the atten	Physic	1 Yes 2 No 9 🗸 U	Inknown	nown	2 _ 0	ther (Specify)			13	
tal Records, P.O. B cian: The law requires that the d certificate has been signed by the ector, page 2 should be detached	F P	Part II. Other significant cond	ditions contributing	to death but no	ot resulting in the	underlying cause	e given in Part I.	23e. Did	tobacco use contril	oute to the cause of death?
ires the signe signe	d by							_ 1 Y	es 2 🗸 No 3	Probably 4 Unknown
of Vital Records, ng Physician: The law requir Wher this certificate has been s meral director, page 2 should 1	Completed								opsy p	Vere autopsy findings available rior to completion of cause of
Rec(The la icate ha	E									eath? ✔ Yes 2 No
tal R cian: 1 certific ector, p	Be C	25. Was case referred to medic				26.Pla	ce of Death (Ch	eck only one)		
Vit hysic this o	일	1 ✓ Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpatien		-	rsing Home 5	Residence 6	
n of ding Ph		27. Manner of Death 1 Natural 5 Pe	EQ!MRT	e of Injury th, Day,Year) D:	28b. Time of FOUND:		ijury at Work?	28d. Describ Subject as	e how injury occurre ssaulted	ed
Division tal or Attendi rs after death al Director: /	ertification	5 Pe	vestigation Apr 21	, 2009	1530 hrs	Ye -	Yes 2 ✔ No	201	(0)	Design Number Office
Jivis II or A safter I Dire	Ě	do	ould not be		At home, farm, stre	eet, factory, office	e building, etc.	or Town		er or Rural Route Number, City
Divisior Hospital or Attend 24 hours after death Funeral Director: tely filled in by the	၂ ပ	4 Homicide	10,000	Multi-Fa		read at the time	data and wlass	1		
Division of Vital Doubside Attending Physician: within 24 hours after death To the Funeral Director: After this certific completely filled in by the funeral director,	edical	(Check only Certifying	Physician: To the b xaminer: On the basis	s of examination						
To To Too	Med	29b. Signature and title of certi	and manner	stated.	7	29c. Lice	nse number		29d. Date signe	ed (Month, Day, Year)
		6.	115	//		0.0	C.M.E.		April 22, 20	09
		30. Name and address of pers	on who completed ca	use of death (I	tem 23a					
		Zabiullah Ali, M.D.	Assistant Med	ical Examir	ner 111 Pe	nn Street, Ba	altimore, MD	21201		
S Regis	tate	A 1 1 1 1 4 3	4 2009 32.	egistrar's Sign	natura.	ale				
IXEGIS	45 (4)	7(11)			- T					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Aori SPELLER 200 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner altimore 8. Date of Birth Month, Day, Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** Min. NOVTH Months Days Hours 1 2 F Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Int. If Item 27 Is marked other than "natural", or items 23a or 28a-f show 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show 1 Nes 2 No Funeral Director :SSe baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 2122 ace. 1 ve 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 2 **X**No 1 ☐ Yes Specify: Black Completed by 3 Widowed 4 Divorced Year or Dates event, the Medical 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation Decedent's Education (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) University 8. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Department of Health and Menta Important: If Item 27 Is marked any injury or other traumatic er once. မ Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) eller lace Drive MD 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🕶 remation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address alto m 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** MEMSMATIC disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Erner Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the bunal-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 5 Other (specify) cate has been signed by the a page 2 should be detached it ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 **□**(No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed After this certificate 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 🖪 No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 1 Yes 2 No Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Natural Injury 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital 29a. Certifier 🕊 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) D006650 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PAND BALTIMORE NAIMISH 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Physician John Gilbert Squires 19, 2009 A M 6:00 April /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 354 Townsend Road Baltimore Co. Essex Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, 5. Social Security Number 6. Sex 1 M 2 □ F **Funeral** Days Hours 82 June 3, Yrs 218-18-2152 Maryland 1926 Director Usual Residence of Decedent be filed within 72 hours after death with the Maryland ntal Hygiene. 10d. Inside City Limits 10c. City. Town or Location 10b. County 10a State ed other than "natural", or items 23a or 28a-f show event, the Modical Exerciper must be notified at 1 ☐ Yes 2 X No Essex Director Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21221 354 Townsend Road United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 X Yes 2 ☐ If Yes, Give Year or Dates: 2 □ No 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: ò White 3 N Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Baltimore City Chauffeur Foreman 8 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be if Health and Mental I item 27 is marked of Eva Catherine Hartlove John Michael Squires 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Essex, Maryland (Daughter) Dawn Squires 354 Townsend Road 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages 1 Department of H Important; If ite any injury or ot 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Hilltop Service Corp. 4/22/2009 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, neral Se icense 21222 Dundalk, Maryland 7922 Wise Ave. 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final week **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last certificate be executed burial-transit Exami ,à Due to (or as a consequence of) attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy signed by the atten d be detached for u 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 No peen s Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe 1 ☐Yes 2 No 2 □ No certificate ours after death.

neral Director: After this certific filled in by the funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death I or Attending F after death. 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 T Homicide

Box 68760, o <u>.</u> Division of Vital Records, Hospital

Baltimore, Maryland 21215-0036

To the within 2 To the I 0,

24 hours a

29a. Certifier

Au

31. Date filed (Month, Day,

Year

ADR 24 2009

Medical

DHMH 17 Rev 1/2001

Registrar

2

ORIGINAL

completed cause of death (Item 23a) (Type, Print)

MD

3. Registrar's Signature

Descertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

20

2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 7:30 p M 22, April 2009 Scott Gladys /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Dundalk Genesis Eldercare- Heritage Center If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) 5. Social Security Number Funeral Days 1 □ M 2 🖼 F 90 September 24,1918 Pennsylvania Director 214-76--3038 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location the Maryland 10b. County 10a. State iral", or items 23a or 28a-f show 1 ☐ Yes 2X No Dundalk Director Md. Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 21222 USA 2402 E. Branch Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 □Yes 2 🛣 No Specify. Completed by 3X Widowed 4 ☐ Divorced "natural" 16b. Kind of Business/Industry Department of Health and Mental Hygiene important: If Item 27 is marked other than "natur any injury or other traumatic event, the Medical since." 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) House Wife Own Home 8 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gladys Maude Hinkle Charles Bernard Fullmer ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2402 E. Branch Road, Dundalk Maryland 21222 Son John W. Wetzel 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) April 27. 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Dundalk, Maryland Oak Lawn Cemetery 2009 4 Donation 5 Other (Specify) 22. Name and Address of Facility

Connelly Fune Connelly Funeral Home Of Dundalk, 7110 Sollers Point Road, Dundalk, To not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betw 23a. Part 1. Enter the disease, or dishock, or heart failure. List of mplications that caused the death. ly one cause on each line. C Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) ed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 ☐Yes 2 ☐No certificate 2 No 1 □Yes 25. Was case referred t edical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this . Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Man er of Death 1 Matural 5 Pending investigation 1 ☐Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) and title of certifier 29b. Signature death (Item 23a) Doe, Print M 31. Date filed (Month State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Id #5 per Fh g892 6/8/09 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. / 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Robert Elmer Stansfield, Jr. 6-09 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Carroll Westminster Carroll Hospital Center Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 2491 218-18-2490 Marylan Director 91 Feb 2, 1918 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 Is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Mental 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 ☐ Yes 2 No Director Sykesville MD Carroll 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21784 U.S.A 7200 Third Avenue, Apt. 109 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1.2 Yes 2 No If Yes, Give Year or Dates: 6/19/ 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 6/30/1945 Saltimore, Maryland 21215-0036 1 □Yes 2. No Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced 6/19/1946 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College [1-4or 5+) **Agriculture** Agriculture 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Elmer Stansfield, Sr. Della Amoss 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7200 Third Ave Apt 109 Sykesville, MD 21784 Ruth G. Stansfield 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Buriel 2 ☑ Cremation 3 ☐ Bernoval from State 4 ☐ Constion 5 ☐ Other (Specify) Apr 20, 2009 Glen Burnie, MD Atlanttic Crematory, LLC 22. Name and Address of Facility ignat Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death GEREBROVASCULAR ACCIDENT ediate Cause (Final **Physician** ease or condition esulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as 1 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 9 DlJnknown 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DISEASE 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate has 1 ☐ Yes 2 ☐ No 1 ☐ Yes Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ⊟Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 or Attending 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation hours after death uneral Director: filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30263 4-16-09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 200 MEMORIAL AVENUE, WESTMINSTER, MD KHOO, MD FRANCIS 31. Date filed (Month, Day, Year) State park Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene fcr -State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician William B. Sterling /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number **Funeral** Days Min Months 1 M 2 □ F 218-16-6480 89 Jan 18, 1920 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2√☐ No MD Somerset Director Crisfield 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 504 Johnson Creek Road items 23a 21817 USA Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 No If Yes, Give Year or Dates: WWII 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 😾 No Specify: Specify: ģ white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Department of Health and Nential Hygiene. Important; If item 27 is marked other than any injury or other traumatic executions. Elementary/Secondary (0-12) College (1-4or 5+) custodian seafood_company 18. Mother's Name (First, Middle, Maiden Surname) .17. Father's Name (First, Middle, Last) William H. Sterling Mary Ann Hickman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Norma L. Bradshaw/niece 156 Some Cove Apts Crisfield, MD 21817 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ★ Other (Specify) in state 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Raltimore, MD 21201 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shook, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 54cars. Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy Year in the past 12 months? Month Dav 5 Other (specify) cate has been signed by the a page 2 should be detached to 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I <u>۾</u> 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No certificate 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours a ler death
To the Funeral Circotor: After this certific completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide TX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

All Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier mhe Neile 2009 005/359

Registrar
DHMH 17 Rev 1/2001

State

DIVISION ST

1415-5.

Registrar's Signature

SALISBURY

MD21804

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. USHA

APR 24

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 6:35 PM M Joan B. Scott April 7, 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 6334 Cedar Lane Columbia Howard 8. Date of Birth (Month, Day, Apr 27, 9. Birthplace (State or Foreign Country) New York 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) **Funeral** Year) 1933 Months Days Hours Min. 1 □ M 2 😿 F 75 119-26-7837 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 28a-f show the Medical Examiner must be notified at 1 ☐Yes 2☐No Director MD Howard COlumbia 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code 5 6334 Cedar Lane 21044 USA items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐Yes 2X No Specify Specify: White 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) unk (Give kind of work done during most of working life. DO NOT use retired) is marked other than College (1-4or 5+) Elementary/Secondary (0-12) 12 bookkeeper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file.
Department of Health and Mental Himportant: If liem 27 is marked oth any linjury or other traumatic evenions. Be David Bernstein Kate Tempkin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen Meyers/daughter 8015 Watermill Court Elkridge, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signa un of Euneral Service Licensee Ronald S. Wad 22. Name and Address of Facility State Anatomy Board Baltimore, MD 21201 rector 655 W. Baltimore Street 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** BLADDER MONTHS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, in the July leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Yes 2121No 5 Other (specify) P.O. After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 9 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 MOther (Specify) 1 ☐ Yes 2 X No HOSPICE Certification: To 28c. Injury at Work? To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending Injury 1 □Yes 2 □ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🚝 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated cal Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier D64395

State Registrar DANIEUE

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

DOBERMANIMO 6565 N CHAPLES STIBUTE 209 BALTIMINE. MO 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #9, 10g, 15, 16a b 18, Per ANA Bd G89812/14/09 JH 1 - For State Registrar amend #19a&b Per INF G398.12/30/09 IH Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year 3:30AM 2009 JaFael 4c. County of Deeth 4b. City, Town, or Location of Death 4e. Facility Name (If not institution, give street and number) Washington Agerstown 1/and Mari prectional 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Age (In yrs. last birthday 5. Social Security Number 6. Sex Days Hours Min 1 1 M 2 □ F 63 Vrs 10/22 575-86-6251 Puerto Rico Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2 ☐ No MD Washington Hagerstown unic 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 18601 Roxbury Rpad 21746 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: Puerto Rican 1 Never Married 2 Married 1X Yes 2□ No Specify: mexican 3 ☐ Widowed 4 ☑ Divorced -unk 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) Hospitality unk 0 Chef 8 unk 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Gloria Berrios Francisco Sevilla 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2005 Grand Ave.apt 3E Bronx, N.Y. 10453
2542 Naylor Road SE #T1 Washington, DC 20020 192 Informant's Name/Relationship (Type Print) Clory Z Seyilla/daughter 10013c D. Cross/111cm 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☑ Other (Specify) in state 21. Sign ture of Funeral Service Licensee, Ronald S. Wade 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 m 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition ENdStage Liver Disease w Heratic Exceptaloguit resulting in death) 155hasis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Dav 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Aricle. E50 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nai autopsy performed 200 No 2 No 1 Yes 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Npatient 2 ER/Outpatient 3 DOA 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Injury 5 Pending 1 Natural
2 Accident 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Dey, Year) 29c. License numbe 29b. Signature and title of certifier

certificate be executed Box 68760, P.0. Records. Division of Vital ō Hospitel To the

Physician

/Medical

Examiner

Funeral

Director

rai', or items 23a or 28a-f show Examiner must be notified at

"natural". or than "natural E

other

Pages 1 and 2 should be fit iment of Health and Mental H lant: If item 27 is marked others.

other

0 permit. Page Department of Important: If any injury or

Physician

/Medical Examiner

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72 within

Maryland 21215-0036

Baltimore,

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) 4 2009

30. Name and address of

erson who completed cause of death (Item 23a) (Type, Print) VA Joubert, M 1860 | K 2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland/Department of Health and Mental Hygiene

				1 - State Amend Item 2	per me,	890°0	4/23/09dl rtificate of	Death	R	eg. No.200	9 131	67
		Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Deat Month	Day Ye		
	J.	/Medic	al	Geraldine Scotland 4a. Facility Name (If not institution, give street and	number)		4h City Town o	or Location of Death	rebru	4c. County of D	009 1149	/ * M
4	. act	Examin	er	Doctor's Community Ho			Lanham	Location of Death		1	George's	
		Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Yea <i>r</i>) 9.	Birthplace (State or Country)	r Foreign unk
12		Director		578-56-1702 1□ M 2 X	66	Yrs.			Sept 15	1942		
. <		land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City	y Limits
0		Mary a-f sh	to	MD Prince Georg	e's B	owie					1 □ Yes	2√ No
7		or 28	Direc	10e. Street and Number			10f. Zip Code	0.71.6	1	0g. Citizen of What	Country?	
SERALDINE		s 23a	Funeral Director	6704 Alexis Drive		1.0		0716		USA	American Indian	
9		items	Fune	11. Marital Status 1 Never Married 2 Married 12. Was I	Decedent Ever in U.S I Forces? Es 2 12 No	5. 13.	 Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 			Black, W	14. Race - American Indian, Black, White, etc.	
3	036	urs af al", or Exam	ρ	If Yes	Give or Dates:		1 ☐ Yes 2X No Specify:			Specify:	white	
Scoturals,	5-0	within 72 hours after death with the Maryland lene. than "natural", or items 23a or 28a-f show he Medical Examine must be retified at	Be Completed	15. Decedent's Education (Specify only highest grade complete	ed)	(Give	dent's Usual Occu kind of work done	during most of work	unk _{king}	16b. Kind of Busine	ss/Industry	unk
th	121	within ene.	dmc	Elementary/Secondary (0-12) Collegunk unk	e (1-4or 5+)	life.	DO NOT use retire	a)				
50	102	il Hygi other rent, I	Č	17. Father's Name (First, Middle, Last)			unk	18. Mother's Nam	e (First, Middle, i	Maiden Surname)		unk
S	/lar	Menta Menta arked atic ev	TO E									
	Mar	rd 2 sho Ith and 27 Is ma		19a. Informant's Name/Relationship (Type. Print) Doctor's Community H	ospital			k Road La		r, City or Town, Sta 20706	ie, Zip Code)	
	ore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinas must be rutified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal fi		lace of Dispo emetery, crea	osition (Name of matory or other pla	ce)	Date	20c. Location - City	or Town, State	
	Baltimore, Maryland 21215-0036			4 □ Donation 5 MOther (Specify) in 21. Signature of Funeral Service Licensee the Signature of Funeral Service Licensee the Signature of Funeral Service Licensee the Signature of Funeral Service Signature of Funeral Service Signature of Funeral Service S	state	, c ² ;	2. Name and Addr	ess of Facility are	1 655 W	Baltimor	e Street	
	ä	and Dec		1000///	lece	B	altimore,	MD 2120)1		6	\mathcal{V}_{\perp}
	П			23a. Part 1. Enter the disease or complications the shock, or heart failure. List only one cause	at caused the death on each line.	. Do not en	ter the mode of dy	ing, such as cardiac	or respiratory are	rest,	Approximate Interval Betw Onset and D	» veen Death
4		Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	ESPIR		RY	FAILUR	RE	A MIERO		
	7	Examiner		B	to (or as a consequ		PNEW	MONIA	2Mc	DICAL EXAMINE		
		p #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	to (or as a consequ			160	LAPROVED BY MI			
		ecute and trans	Examiner	triat illitiated events C.	OMA to (or as a consequ	ience of).		FRITEICATIO	Wie	DICH EXAMPLES		
	68760,	rtificate be executed ng physician and as the burial-transit		L _d . A	VOXIC		VCEPI	HALOP	ATH	(
	68	rtificat ng ph) as the	Medical	IF FEMALE:								
	Вох			23b. Was decedent pregnant	outcome of pregna ive birth 2 ☐ Fetal	death 3	Ectopic pregnan	су		23d. Date of Month		/ear
	P.0.	w requires that the death co s been signed by the attend should be detached for use	Physician/		regnant at time of d inknown	eatn 5t	Other (specify)					
	S, F	es that igned to be deta	by P	Part II. Other significant conditions contributing	to death but not resu	Iting in the u	nderlying cause gi	ven in Part I.			te to the cause of de	
	ord	een s	ted	HYPONATREMIA	+				1 L Y		Probably 4 🖭	
	of Vital Records,	8 8 8	Completed	HIPOTENSION					24a. Was a autop: perfor	med? deat	e autopsy findings a r to completion of ca th?	available ause of
7	ta	sician: The lav certificate has rector, page 2	Be Co	25. Was case referred to medical			_	26. Place of Dea	1 ☐ Yes th (Check only or		Yes 2□No	
2	of V	hysic his ce I direc		examiner? 1 X Yes 2 No Hospital:			III 3 LI DOA			ence 6 Other (Specify)	
3		ding P	ion		late of Injury Month, Day, Year)	28b. Time of Injury	Wo	ıryat rk?]Yes 2∐No	28d. Describe h	ow injury occurred		
9	Division	Attend r death cctor:	ficat	Z D Accident	lace of Injury - At ho uilding, etc. (Specify	me, farm, st		1163 2 110	28f. Location (S	treet and Number of	or Rural Route Numi	ber,
	Ö	ital or its after al Direction bed in the	Certification: To						City or Tow			
		To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page.	Medical	29a. Certifier (Check only one) 1 **Certifying Physician: To the control of the	o the best of my kno he basis of examina nanner stated.	wledge, dea tion and/or i	th occurred at the to nvestigation, in my	time, date and place opinion, death occu	e, and due to the earred at the time, of	cause(s) and mann date and place, and	er as stated. due to the cause(s))
4		To th Within	Me	29b. Signature and title of certifier.	m			se number	:	29d. Date signed (A		
				30. Name and address of person who completed Kevin Erfan, mp.	SUS GO	23a) (Type,	Print)	Lahh	am, m	100 20	106	
		State		Kevin Erfan mD. 31. Date filed (Month, Day, Year) APR 23 2009	2. Registrar's Signa	ture	ارا	1				
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			State of Marylar State of Marylar Registrar		artment of H			giene Reg. No. 2009	13168
	Physicia		1. Decedent's Name (First, Middle, Last)				2. Date of Dea Month	Day Year	3. Time of Death
1	/Medic Examin		, Olik I This SE	s. last birthday) Yrs.	Leona	Location of Death If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da 1/7/19	4c. County of Dea	thplace (State or Foreign
	Director		Usual Residence of Decedent				1/ // 19	06 Mar	yland 10d. Inside City Limits
	Marylar f show	to		City, Town or Lo USby	ocation				1 X Yes 2 □ No
	or 28a	Director	10e. Street and Number	7	10f. Zip Code			10g. Citizen of What Co	ountry?
	ns 23a	Funeral	Unknown 11. Marital Status 12. Was Decedent Ever in the status in the	U.S. 13.	20657 Was Decedent of Hill Yes, specify Cuba	spanic Origin? (Sp	ecify Yes or No	U.S.A.	
036	should be filed within 72 hours after death with the Maryland and Mental Hygiene. marked other than "natural" or items 23a or 28a-f show marked other than "natural" or items 23a or 28a-f show matic event, the Medical Examinant nast be nothed at	þ	Armed Forces? 1 Never Married 2 X Married 1 Yes 2 X No If Yes, Give 3 Widowed 4 Divorced Year or Dates:	i	If Yes, specify Cuba 1 □Yes 2 🛛 No	n, Mexican, Puerto Specify:	Hican, etc.)	Black, Whit	
Maryland 21215-0036	hin 72 ho e. an "natur Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	luring most of worki	ing	16b. Kind of Business	_
d 21	filed with Hygiene ther the		12 17. Father's Name (First, Middle, Last)	С	hef	18. Mother's Name	(First, Middle,	Food Serv	rice
/lan	e d al	To Be	John Henry Willis			Mary Aga	atha Bi	scoe	
Mary	200		19a. Informant's Name/Relationship (Type. Print) Patrick Willis/ Brother	117	ng Address (Street a			er, City or Town, State,	Zip Code)
	es 1 and 2 of Health filtem 27 i		20a. Method of Disposition 20b.	. Place of Dispo	osition (Name of matory or other place		Date	20c. Location - City or	Town, State
	permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Source Licensee		ts Registry			Hanover, M	•
Ba	permit. Departr Importa any Inju		S O	7	522 Conne	lley Dr.	stomy G . Ste.P	ifts Regist , Hanover,	ry MD 21076
H			23a. Part1. Enter the disease, or complications that caused the dea shock, or heart failure. List only one cause on each line.	ath. Do not en	ter the mode of dyin	g, such as cardiac	or respiratory a	rrest,	Approximate Interval Between Onset and Death
	hysician /Medical		disease or condition resulting in death) Due to (or as a conse	equence of):	rrhy than	~			mark
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8	ecuted nd transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	deal	in faret	· m			minte
8760, 3	cate be executed ohysician and the burial-transit	dical Ex	resulting in death) Last Due to (or as a conse	equence of):					
O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnant at time or 9 □ Unknown	etal death 3	☐ Ectopic pregnanc ☐ Other (<i>sp</i> ec <i>ify</i>) _	у		23d. Date of de Month	olivery Day Year
rds, P.	quires that n signed b	by	Part II. Other significant conditions contributing to death but not re	esulting in the u	underlying cause giv	en in Part I.		obacco use contribute t Yes 2 ☐ No 3 ☐ F	to the cause of death? Probably 4 🗹 Unknown
		Completed					24a. Was auto perfo	ormed? death?	utopsy findings available completion of cause of s 2 \(\subsection \) No
Vital	sician: The scertificate ha	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 21	☑ ER/Outpatie	ont 3 🗆 DOA Oth	26. Place of Deat	,	one) dence 6 ☐ Other (Sp	acihi)
n of	ding Phys h. After this funeral dir	on: Tc	27. Manner of Death 1-Natural 5 Pending (Month, Day, Year)	28b. Time o	of 28c. Injur Worl	y at		how injury occurred	өспу)
Division of	or Atten	Certification: To	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At building, etc. (Special Country - At building, etc.)	home, farm, st		Yes 2□No	28f. Location (City or To	Street and Number or F wn, State)	Rural Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical Ce	29a. Certifier (Check only one) 29 Medicel Examiner: On the basis of examiner and manner stated.	nowledge, dea ination and/or i	th occurred at the tin nvestigation, in my c	me, date and place, pinion, death occur	and due to the red at the time,	cause(s) and manner and date and place, and du	as stated. ue to the cause(s)
	To the within 2 To the сотре	Me	29b. Signature and title of certifier		29c. Licens	e number		29d. Date signed (Mor	oth, Day, Year)
			30. Name and address of person who completed cause of death (It.	tem 23a) (Type.	Print)	7 65 38	5	theil	17,2015
	1		Alex rosis po Bo	× 57		eonard +	0 ~-,	Mp 2	_0650
	Sta Registi		31. Date filed (Month, 2av4 Yag 2009 32. Registrar's S	nature	To/				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 12:45 IURNER LOUISE 2009 21 APRIL /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Town or Location of Death Examiner Hospita timore Date of Birth (Month, Day, Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Min. Davs Months ass-42.0497 1 ☐ M 2 💢 F Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Expriner rulet be notified. 10d. Inside City Limits 10b. County 10a State 10c. City, Town or Location 1 Yes 2 □ No Funeral Director baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11, Marital Status Black, White, etc. 1 ☐Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 No Baltimore, Maryland 21215-0036 1 □ Yes 2 □ **C**o Specify ģ 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired). 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Ivear Mother's Name (First, Middle, Majden Surname, 17. Father's Name (First, Middle, Last) Be ပ Rural Route Number, City or Town, State, Zip Code) r., Apt. B. Batto, MD 21206

Date | 20c. Location - City of Town Co. rmant's Name/Re ationship (Type. Prig 19b. Mailing Address (Street and Number or f12 liam 700 20c. Location - City or Savanna 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fureral Service Lice 0 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Mmlks Immediate Cause (Final Kanvias **Physician** (a disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last burial-tra Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown signed by t the detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Š 2 No 3 Probably 4 ★Unknown 1 🗌 Yes nis certificate has been s director, page 2 should i Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 **X**No 1 ☐ Yes 2 **N**No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 npatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After t 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident Director; 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day,

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Thaw Poon

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

eorge momas		1- For State	partificate of Death		1. No. 200	9 131
Physici	an/	Registrar 1. Decedent's Name (First, Middle,Last)	·-1	2. Date of Death		3. Time of Death 1030 hrs
Medical Exami	ner	4a. Facility Name (st. pdt institution, give street and number)	Thomas 4b. City, Town, or Location of Death	April 20, 20	4c. County of Death	
		4200 Northern Parkway	Baltimore			
Funeral)	5. Social Security Number 6. Sex 7. Age (In year)	rs. last birthday) If Under 1 Year If Under 24Hr Months Days Hours Min		(MM/DD/YYYY) g. Birt Foreig	n
Director		244-44-1036 17M 20F	Yrs.	01-10	-1932 co	untry) VA
any	ł	Usual Residence of Decedent 10a. State 10b. County 10c. Co	City, Town or Location			10d. Inside City Limits
ind show	٦	MD Baltimore B	altimore			1 Yes 2 No
ne Maryland or 28a-f show any ffed at once.	recto	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Cour	ntry?
ith the Maryland 23a or 28a-f sho notified at once	Ö	6805 Eastridge Rd 11. Marital Status 12. Was decedent Ever i	n U.S. 13. Was Decedent of Hispanic Origin? (S	Incoin Voc or No	USH 14 Bass Ameri	can Indian, Black,
0036 within 72 hours after death with the Maryland jene. her than "natural", or items 23a or 28a-f sho Medical Examiner must be notified at once	Funeral Director	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 N	If Yes, specify Cuban, Mexican, Puerto		White, etc.	
after d 'al'', or	by Fi	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 No specify:		Specify:	
hours "natur	ted	15. Decedent's Education (Specify only highest grade completed Elementary/Secondary (0-12) College (1-4 or 5+)	1) 16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use re		16b. Kind of Business/I	Industry
036 thin 72 ne.	Completed	8-tharade	Mechanic		Auto	
15-0 Tiled wi Hygie d other	S	17. Father's Name (First, Middle, Last)		e (First, Middle, M		2.6
21215-0036 suld be filed within 7 Mental Hygiene. marked other than c event, the Medica	To Be	19a. Informant's Na e/Relationship (Type, Print)	19b. Mailing Address (Street and Number of	Rural Route Num	Spence ber, City r Town, State	e, Zip Code)
and sho		Jean E. Thomas/Wife	6805 Eastrido			
re, M s I and 2 of Health If item 2		1 Rurial 2 Cremation 3 Removal from State	Ob. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or	_
. 드 를 를 들 등		4 Donation 5 Other Specify:	Vood laun Cemetry 4.	-25-09	Woodla	
Balt permit. Departi Import		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Vo	mann c		fungal sn m, MD 2113
Physician		23a. Part I. Enter the disease, or complications that caused the defailure. List only one cause on each line.		or respiratory arre		proximate Interval Between Onset and
/Medical caminer		Immediate Cause (Final disease a Hypertensive Athero	sclerotic Cardiovascular Disease			Death
		or condition resulting in death) Due to (or as a consequent	ce of):			
	ner	Sequentially list conditions, if any, leading to immediate Cause. Enter Underlying Cause	ce of):			1
0	Examiner	(Disease or injury that initiated events resulting in death) Last	ce of):			+
Mg and transit		d				
ਲੇ ਛਿਢੀ	Medical	UNPENDED AMENDED			23d. Date of deliver	
3876 rtificat ing phy as the		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of past 12 months?	pregnancy 2 Fetal death 3 Ectopic pregi	nancy		y Day Year
Box 687 e death certific the attending p	Physician/	1 Yes 2 No 9 Unknown g Unknown	of death 5 Other (Specify)		8	
C, th V, th			not resulting in the underlying cause given in Part I.	23e. Did to	bacco use contribute to	the cause of death?
ires that the signed by	d by	Leukemia		1 Yes	2 No 3 Pro	bably 4 Unknown
ords, F w requires as been sign should be	plete			24a. Was a autop	sy prior to	utopsy findings available completion of cause of
tal Rec sian: The la certificate h: ector, page 2	Completed					es 2 No
Division of Vital Records, pital or Attending Physician: The law require ours after death. In a Director: After this certificate has been siftled in by the funeral director, page 2 should b.	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2	26.Place of Death (Chec		Residence 6 ✔ Othe	er: Scene
of Vii ing Physi After this	. To	1 V Yes 2 No Page 1 1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	28b. Time of Injury 28c. Injury at Work?		now injury occurred	
ion tendin eath. tor: A	atior	1 Matural 5 Pending 2 Accident Investigation	1 Yes 2 No			
jyis For At after d Direc	Certification:	3 Suicide 6 Could not be 28e. Place of Injury -	At home, farm, street, factory, office building, etc.	28f. Location (S or Town, S		ural Route Number, City
Division Hospital or Attend 24 hours after death Funeral Director:		29a. Certifier	wledge, death occurred at the time, date and place, a	ad due to the caus	e(s) and manner as sta	ted.
To the Hos within 24 h To the Fur	Medical	(Check only one) 2 Medical Examiner: On the basis of examinati and manner stated.	on and/or investigation, in my opinion, death occurred	at the time, date	and place, and due to the	he cause(s)
F * F 8	Me	29b. Signature and title of certifier	29c. License number		29d. Date signed (Mo	onth, Day, Year)
		Pamele 9 Southall, me	O.C.M.E.		April 21, 2009	
1		30. Name and address of person who completed cause of death Pamela E. Southall, MD Assistant Medical I		MD 21201		
	tate	31. Date filed (Month, Day, Year) 2. Registrar's Sig	anature .			
Regis		APR 24 2009 Skrew	S. parl	X.,		
DHMH 17 Rev 1/2	2001		ORIGINAL			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician 920 AM Verable 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** ELLI COLT WA If Under 1 Year Date of Birth (Month, Day, 9. Birthplace Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. 6 Sex **Funeral** Year) 1 □ M 2 🗷 F Months Days Hours Min. 401-46-9986 Usual Residence of Decedent KEINEULKY Director 10c. City, Town or Location 10d. Inside City Limits 10b. County I amu c annown...
Health and Mental Hygiene.
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Health 1 XYes 2 □ No Director ELLICOTT CI HOWAR 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA Completed by Funeral death v . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Man If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Specify: BLACK Saltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify 3 ☐ Widowed 4 💆 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MEDICIAL 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be DANIEL BALLEW ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other trau TRACIE PREVOSE - DAUGHER 4626 CHATS WORTH UX ELLICOTECT +X MD 21043 Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/27/09 NEW ORLEAMS, LA 4 Donation 5 Dother (Specify) 22. Name and Address of Facility EUNEKL HOME 21. Signature of Fundal Service Licensee 12550 FORG 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Examiner Due to or as a consequence of Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 ☐ Ectopic pregnancy Month Year 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No Ö 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed certificate 2 □No 1 □Yes 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 1 Yes 2 ₩No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After Division To the Hospital or Attending 1 Natural 2 Accident 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐Yes 2 ☐ No death. 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

State Registrar

29b. Signature and title of certifier

30. Name and address of

500

person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's S

1105

29c. License number

2. Date of Death

Month

Пау

Year

3. Time of Death

1 - For State Registrar

1. Decedent's Name (First, Middle, Last)

Physician 12:48a^M Stanley Volciak April 23 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Towson Stella Maris-Hospice If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) August 22, 1914 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 1 X M 2 □ F 94 210-03-8421 Pennsylvania Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Weden Examiner is ust be notified at once. 10b. Count 1 ☐ Yes 2 XNo **Funeral Director** Dundalk Baltimore Md. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7423 Hill Court 21222 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 M Married 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Bethlehem Steel Steel Worker 12 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Baltimore, Maryland Be Anna Zakraysek Stanley Volcjak မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marlene A. Holland Daughter 1622 Windemere Drive, SanMarcos CA. 92078 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State April 27 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens Of Faith Cem. Rosedale, Maryland 2009 4 ☐ Donation 5 ☐ Other (Specify) ^{22. Name and Address of Facility}
Connelly Funeral Home Of Dundalk,
7110 Sollers Point Road, Dundalk, Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) PNEUMONIA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying trause (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-tran Due to (or as a consequence of) attending physician for use as the burial Physician: The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy cate has been signed by the atte page 2 should be detached for i Month Day Year 4 ☐ Pregnant at time of death
9 ☐ Unknown 5 Other (specify) 1 ☐Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2X No certificate 1 ☐ Yes 1 🗌 Yes 2 □ No ne Hospital or Attending Physician: 7 n 24 hours after death.

The Funeral Director: After this certifical aletely filled in by the funeral director, ps 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 NOther (Specify) HOSPICE 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To ð 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funeral D completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical One X Nurse Practitioner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 4-23-2009 Dorothea (anolland KSM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DOROTHEA MAHOLLAND, RSM CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #8, 13,14, per Fh 8892 6/1/09 TT

State of Maryland / Department of Health and Mental Hygiene
AMEND ITEM#/perfH, C892, 6/3/09 WS

trar

Certificate of Death

Reg. No. 2 0 0 9 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 24 2ඊඊ9 6:05a M CLARA WHITE /Medical 4a. Facility Name (If not institution, give street and number) Apt. 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 208 Baltimore Pikesville 7219 Park Heights Avenue If Under 1 Year | If Under 24 Hrs. 1914 9. Birthplace (State or Foreign Country) 8. Date of Birth Month, Day, Y Social Security Number 7. Age (In yrs. last birthday) 6. Sex Year) **Funeral** Months Days Min. 1 □ M **X**XF 240-03-9364 Yrs Director VΑ 95 94 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County than "natural", or Items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at MD 1 ☐ Yes 2 K No Director Baltimore Pikesville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Apt. 208 21208 Funeral 7219 Park Heights Avenue USA 14. Race - American Indian, Black, White, etc. **Puerto** 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritai Status 1 ∐Yes 2**X** No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 XYes → → Baltimore, Maryland 21215-0036 Specify: Black Rican ģ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/A Disabled llth N/A18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ida Jenkins ပ Anthony Cloyd 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Apt. 208 Juanita Cloyd-daughter 7219 Park Heights Ave. MD 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Surial 2 ☐ Cremation 3 ☐ Removal from State King Memorial Pk. 4/25/09 Randallstown MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MARCH FUNERAL HOME-EAST D Wa 1101 E. North Avenue Baltimore, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 ☐ Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ nknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) Certification: To 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Medical 29a. Certifier The certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year)
APW 2(20 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Cerurly So Tonson A 32. Registrar's Signature 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 1/2001

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36 hin 72 h e. than "r	Completed	Elementary/Secondary (0-12) College (1-4 or	5+)	memolo	wed		unemp	loyed.
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2121 2121 201d be f Mental marke ic event	To Be	19a. Informant's Name/Relationship (Type, Print)	19b.	Mailing Address (Stre	eet and Number or Rura	Route Numbe	r, City or Town, State	, Zip Code)
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at ouce.		4 Donation 5 Other Specify: 21. Si of Funeral e e Licens		22. Name and Addres	ss of Fac ity	ell F	unteral	Mary
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Box 68760, e death certificate by the attending physic ed for use as the but	n/Me	23b. Was decedent pregnant in the 1 Live birth	ome of pregnancy	Fetal death 3	Ectopic pregnancy	,	23d. Date of deliver Month	ry Day Yea r
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Division of Vital Records, P.O. ours after death. Physician: The law requires that the ours after death. Return the law requires that the reral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detach.	Certification:	3 Suicide 6 Could not be 28e. Place of	Injury - At home, fa	rm, street, factory, offic		or Town, Sta Baltimore, MI	ite)	Rural Route Number, City
		29a. Certifier 1 Contifuing Physician: To the best of	my knowledge dea	ath occurred at the time.	, date and place, and du	re to the cause	(s) and manner as sta	ated.
To the Hos within 24 h	Medical	(Check only one) 2 ✓ Medical Examiner: On the basis of examiner: Signature and title of certifier	amination and/or ind.		ion, death occurred at t		29d. Date signed (M	
	Ž	Fond by anithact, mi			C.M.E.		April 21, 2009	
h ./		30. Name an ress of person who completed cause of		r 111 Donn Str	eet, Baltimore, MI	21201		
J V	tate	IPO Pogist	dical Examiner rar's Signature	i iireiii sii	eet, baltimore, ML			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. and #7, \$19a, perFh 9890 4/24/09 TT State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Claude Lester Williams, Jr. 7:25 A Apr 23, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Mt. Airy **Pleasant View Nursing Home** Carroll If Under 1 Year | If Under 24 Hi Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1 2 4 2 □ F 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 86 Director 217-16-5088 MD Jul 15, 1922 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show d other than "natural", or items 23a or 28a-f shovevent, the Modical Evanties must be notified at 1 □Yes 2/No Director MD Howard Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13879 Forsythe Rd. 21784 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after Hygiene. 1 Never Married 2 Married 1 ☐Yes 2 No 3altimore, Maryland 21215-0036 Specify. 2 Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wi Department of Health and Mental Hygien. Important: If item 27 is marked other tha any Injury or other traumatic and once. Optician Evecare 9 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Claude Lester Williams Sr. Christina Burr 19a Prormant's Name/Relationship (Type. Print)
Claudia Lokey
Claudia Williams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Saughter 13879 Forsythe Rd. Sykesville, MD 21784 20a. Method of Dispotition
1 ☐ Burial 2 Cremation 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 3 Removal from State Apr 27, 2009 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD Atlantic Crematory, LLC License Signature of Funeral 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enfer the disease, or complications had caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CONFESTIVE Months CARDIAC FAILURE disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** OF LIVER IRRHOSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ner Due to for as a consequence of. CARDIO MYOPATH Exami and Due to (or as a consequence of): nding physician a Box 68760, certificate be PERTENSION Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery atter 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) P.O. ned by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 2 I No 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) spital or Attending Prours after death.
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DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend Sixtem fall ary Part / Department of the title and Mary Part / Department of the title and the many and the title and the Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Ye ar **Physician** 1:40 M APRIL 2009 16 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Hal If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) Security Number **Funeral** Days 1 □ M 2 💢 F -10 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be nutified at Kaltimore 1 Yes 2 □ No Funeral Director 10g. Citizen of What Country? 10f. Zip Code Willinger 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify Black Completed by 3 ☐ Widowed 4 ☐ Divorced "natural", traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 th and Mental Hygiene. 7 is marked other than "n Elementary/Secondary (0-12) Sollege (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Williams 19b. Mailing Address (Street and Number of Rural Route Number, Sity or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau once. Middle River, Md. Daughter Knite Old 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location -City or Town, State 20a. Method of Disposition

1 □ Burial 2 Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) Balto. -23-09 Greene Funeral Services 21. Signature of Funeral Service Licensee 22. Name and Address of Famility Vaughn 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): HATERY /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Erner Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed Due to (or as a consequence of) physician a s the burial-1 Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) P.0. certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by 1 → res 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Hypertension 24a. Was an autopsy performed? Yes 2 10 1 ☐Yes 2 ☐ No 1 ☐ Yes After this certification funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \sum Nursing Home 5 \textsquare Residence 6 \subsetence Other (Specify) 1 res 2 No decine 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred the Hospital or Attending 1 Natural 5 | Pending within 24 hours after occur.

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 □Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifile APRIL 20. 2009 DO069746 alles MD este 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTMORE 21201 Peter Greene 10 PLAZA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

	02192 pert Warren		Please Type State	or Print in Black Indelie of Maryland / Departm	ible Ink. I ent of Hea ate of Dea	alth and	All Copies Mental Hyg	iene	200	19 1317	
	Physici		Registrar 1. Decedent's Name (First, Middle,La		0, 000			Reg. N Date of Death		3. Time of Death	
Me	dical Exami		Robert Warren					Month Day March 18, 200	/ Year 09	1050 hrs	
	,		4a. Facility Name (if not institution, g Johns Hopkins Hospital	ve street and number)	1 '	y, Town, or L timore	ocation of Death		4c. County of Dea	ith .	
	, Funeral		5. Social Security Numberunk 6.	Sex 7. Age (In yrs. last bir		nder 1 Year	If Under 24Hrs. 8	. Date of Birth(M	M/DD/YYYY) 9. B	irthplace (State orUNK	
	Director			XM 2 F 60		nths Days	Hours Min.	Nov 20,	1948 Fore	eign Country)	
		ŀ	Usual Residence of Decedent	7. 00				110 20			
	ow any		10a. Stateunk 10b. County	un to c. City, Town	or Location				unk	1 Yes 2 No	
٥	ıryland Ia-f sh It once	cto	10e. Street and Number		unk 10f. 2	Zip Code	un	l 10g. 0	Citizen of What Co	untry?	
5	ith the Maryland 23a or 28a-f show notified at once.	Director			din		an.		IICA		
_	ı with ms 23 be no	eral	11. Marital Status unk	Armond Foresco	13. Was Dece	edent of Hisp	oanic Origin? (Speci Mexican, Puerto Ric	fy Yes or No-	14. Race - Ame White, etc.	erican Indian, Black,	
	r death or ite must	Funeral	1 Never Married 2 Marrie	1 Yes 2 No				ian, 6.6.,			
	rs after rraf", niner	à	Widowed 4 Divorce Decedent's Education (Specify)	ed If Yes, Give Year or Dates:	1 Yes		specify: on (Give kind of work	done - 1- 16k	Specify: D. Kind of Busines:	white	
	2 hour "nate	ted	Elementary/Secondary (0-12)	College (1-4 or 5+)	during most of v	working life.	DO NOT use retired	doneunk	. Tang or Boomoo	s/industry unk	
	036 ithin 7 ne. r than ledica	Completed	unk	unk							
	215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	Be Cor	17. Father's Name (First, Middle, Las	st)	u	nk 1	8. Mother's Name (Fi	rst, Middle, Maid	en Surname)	unk	
	21 thould nd Mer is man	2	19a. Informant's Name/Relationship	` '		,	and Number or Rura			ite, Zip Code)	
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumaric event, the Medical Examiner must be notified at once.		O.C.M.E. 20a, Method of Disposition				et Baltimo		c. Location - City	or Town. State	
			1 Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 X Other Specify: in State								
			21. Sign fure of Ronal d So	Wale pirector	IBaiti	Anato more.	omy Board MD 21201			e Street	
	Physician	1	23a. Part I. Enter the disease, or cor fallure. List only one cause on	nplications that caused the death. Do neach line.	ot enter the mod	de of dying,	such as cardiac or re	espiratory arrest,	shock, or heart	Approximate Interval Between Onset and	
1	/Medical xaminer		Immediate Cause (Final disease or condition resulting in death) a Complications of transbronchial biopsy procedure Due to (or as a consequence of)							Death	
ī		Examiner		Due to (or as a consequence of):							
			Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence of):							
	ed nsit		(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):				N.			
	ox 68760, eath certificate be executed attending physician and course as the bunial - transi		XUNPENDED	AMENDED 23a, PII, 27	7,28a-f,	perME	, g892 6/	19/09 тт	-		
	60, ate be shysici te buri	Med	IF FEMALE:	23c. If yes, outcome of pregnancy	,			1	23d. Date of deliv	ery	
	687 sertific ding p	sician/Medical	23b. Was decedent pregnant in the past 12 months?	Dunner of starts	2 Fetal dea		Ectopic pregnanc	у	Month	Day Year	
	Box 68760, re death certificate by the attending physic led for use as the bur	ysic	1 Yes 2 No 9 Unknow	17	5 Other (S	Specify) _					
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	ires the signed be de	d by									
	v request peen should	ompleted						24a. Was an autopsy	prior t	autopsy findings available to completion of cause of	
	Recorrect International Properties of the Parage 2	mo						performed 1 Yes 2			
	al Finan: Terrific ctor, p	BeC	25. Was case referred to medical examiner?				of Death (Check onl	y one)			
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	n of ding F		27. Manner of Death 1 Natural 5 Pending	(Month, Day,Year)	Time of Injury		No 3 X No B		during .	lung biopsy	
	Division of Vital Records, P.O. Batal rate of Attending Physician: The law requires that the detents after death. al Director: After this certificate has been signed by the led in by the funeral director, page 2 should be detached for	cati	2 X Accident Investig	ation 28e Place of Injury - At home	nk farm. street. fact		P	rocedure Sf. Location (Street	et and Number or	Rural Route Number, City	
	i Dia o S	ertification:	3 Suicide 6 Could n 4 Homicide	ot be	54 551, 1401	,		or Town, State	Johns Ho	opkins Hospit	
	To the Hospital within 24 hours a To the Funeral completely filled	ပ	29a. Certifier Certifying Phys	ician: To the best of my knowledge, de	eath occurred at	the time, da	ate and place, and du	ie to the cause(s)	and manner as s	tated.	
	To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examir	ner: On the basis of examination and/or and manner stated.							
		Σ	29b. Signature and title of certifier		- 1	29c. Licens	e number	29	ld. Date signed (/	viontn, Day, Year)	

State 31. Date filed (Month, Day, Year) Registrar

ORIGINAL

30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner O.C.M.E.

111 Penn Street, Baltimore, MD 21201

OCME

March 19, 2009

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DHMH 17 Rev 1/2001 OCME 2006

			•	pe or Print i				-	_		
			For State Registrar	State of Mary		artment of t tificate of			_{eg. No.} 2009	13178	
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Louise D. Wyatt					2. Date of Deat Month April 9	Day Year	3. Time of Death 1:50 PM M	
me.	Examin		4a. Facility Name (If not institution, give st	reet and number)		4b. City, Town, o	r Location of Death	•	4c. County of Deat	h	
الري	Funeral	or	4001 River Crescen 5. Social Security Number 272-03-4108	203 yrs. last birthday) 96 Yrs.	Annapo If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	nnde1 hplace (State or Foreign			
	Director		Usual Residence of Decedent		90			Jan 4,]	1913 Penn	sylvania	
	/arylan f show		MD 10b. County Anne Arun		c. City, Town or Lo Annapol:					10d. Inside City Limits 1 ☐ Yes 2√∑ No	
	r 28a-	Director	10e. Street and Number		•	10f. Zip Code		1	0g. Citizen of What Co	untry?	
	th with	a D	4001 River Cerscen	t Drive #92	203	21	401		USA		
980	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, I'm Te from Exacting the natified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	 Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No if Yes, Give Year or Dates: 		Was Decedent of H fYes, specify Cub I □Yes 2X No	dispanic Origin? (Spe an, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: Wh	e, etc.	
21215-0036	72 hou	eted	15. Decedent's Educa (Specify only highest grade	ition co <i>mpleted)</i>	(Give	dent's Usual Occu kind of work done	during most of working	ng	16b. Kind of Business/	Industry	
121	filed within Hygiene. Other than '	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		oo NOT use retire nomemaker	,		own home		
nd 2	e filed al Hyg sother	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, I		·	
yla	2 should be fi and Mental I is marked of aumatic ever	10 E	Erskine Sill Dunla				Ruth Ha	,			
Maryland	d2sh Ith and 17 is m traum		19a. informant's Name/Relationship (Type Katherine DeWitt/d				Lane Rest		r, City or Town, State, 2 20190	Zip Code)	
	ges 1 and 2 it of Health If item 27 i or other tra		20a. Method of Disposition	2	0b. Place of Dispo		D		20c. Location - City or	Town, State	
Baltimore,	permit. Pages. Department of Important: If ite any Injury or of		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 💹 Donation 5 ☐ Other (Specify)								
Bal	permit. Pag Department Important: I any Injury o once.		21. Signature of Funeral Service Licensee Ronald S. Wade, Wirector State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201								
	Physician		23a. Part 1. Enter the disease, or complicion shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	ations that caused the cause on each line.			est,	Approximate Interval Between Onset and Death			
أولي	/Medical Examiner	Examiner		Due to or as a co	nsequence of):	11-1	ateria			14 days	
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6876	rificate be executed ng physician and as the burial-transit	dical	d								
O. Box	The law requires that the death certificate ate has been signed by the attending phys bage 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 NO 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 1 1 1 1 1 1 1 1 1						23d. Date of de Month	livery Day Year	
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Vita	slcian: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	26. Place of Death (Check only one)							
of	Hospital or Attending Phys 24 hours after death. Funeral Director: After this tely filled in by the funeral dir	n: To	27. Manner of Death	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Ott 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 4 Work? 28c. Injury at Work?						cify)	
Division		catio	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	n M 1 □Yes 2 □No							
Dİ		Certification:	4 Homicide determined						28f. Location (Street and Number or Rural Route Number, City or Town, State)		
		Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	To the within 2 To the comple	Me	29b. Signature and title of certifier	und m	. p	29c. Licen	icense number 29d. Date signed (Month, Day, Year)				
_			30. Name and address of person who com	repleted cause of death			try Any	rapulis	, W/-2	1401	
	Sta Registr		31. Date filed (Month, Day) Year) APR 2 4 2009	32 Registrar's S	Signature .	tense b		V	,		

DHMH 17 Rev 1/2001

			For State Registrar	State of Ma	ryland /		rtment of H <i>tificate of L</i>		/lental Hy	giene Reg. No.	2005	10112	
	Negistrar 1. Decedent's Name (First, Middle, Last)							2. Date of Death			3. Time of Death		
	Physicia		Howard F. Winner						Month D April 2		Year 2009	1:30 A M	
	/Medic		4a. Facility Name (If not institution,			T	4b. City, Town, or	Location of Death	IIPI II		County of Deat		
1	Examin	er	Shady Grove Ad		nital		Rockvi	11e			Montgo	merv	
	uneral				(In yrs. last	birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir (Month, Da	rth	9. Birt	hplace (State or Foreign	
	orector		173-07-7258	1 X M 2 □ F	89	Yrs.	Months Days	Hours Min.	May 24				
ъ			Usual Residence of Decedent										
ylan	how		10a. State 10b. County		10c. City, T	own or Loc	cation					10d. Inside City Limits	
Ma	a-f s	Director	Maryland Mont	gomery	Pot	tomac						1 □Yes 2XNo	
th th	23a or 28	Jire	10e. Street and Number				10f. Zip Code			10g. Citi	zen of What Co	untry?	
th wi		la	8606 Timber H:	ill Lane			20854				nited S		
d 6.16.13-0000 filed within 72 hours after death with the Maryland	ems	Funeral	11. Marital Status	12. Was Decedent 8 Armed Forces?		13. V	Vas Decedent of H Yes, specify Cuba	ispanic Origin? (S _i an, Mexican, Puerto	pecify Yes or No Rican, etc.)	D-	 Race - Ame Black, White 		
affe S	5		1 ☐ Never Married 2 ☐ Marri	If Yes, Give		1	□Yes 2X No	Specify:			Specify:	n	
Suno	nra n	d by	3 X Widowed 4 ☐ Divorced	Year or Dates:	WWII	S- B	lent's Usual Occup	ation		16h Vi	nd of Business/	hite	
72	"nat	Completed	15. Decedent (Specify only highes	t grade completed)		(Give	kind of work done of NOT use retired	during most of work	king	TOD. IX	na or Basiness/	madon y	
vith 1	ene.	Ĕ	Elementary/Secondary (0-12)	College (1-4or 5	+)		nager	7		De	partmen	t Store	
iled 1	ther int,		17. Father's Name (First, Middle, I	.ast)		1141	lager	18. Mother's Nam	e (First, Middle	<u></u>	<u> </u>		
b e	ental sed o	Be C	Frank C. Win					Eliza	beth He	inli	n		
hould	mark mati	2	19a. Informant's Name/Relationsh			19b Mailin	g Address (Street					Zip Code)	
d 2 s	Ith ar		John Howard W:		1.0		Timber H						
ָב מ	Hea tem 2		20a. Method of Disposition	, 5011	20b. Plac		sition (Name of natory or other place		Date		ocation - City or		
ages	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, its Medical Evantice in unit be notified it once.		1 Burial 2 X Cremation		1		rematorium,	ADLI	1 24 ,	B.o.	thacda	Maryland	
rmit. Pages			4 ☐ Donation 5 ☐ Other (S)		Tonego	22	Name and Addre	ss of Facility					
per n			Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, 7557 Wisconsin Avenue, Bethesda, Maryland 20814									vy Chase, Inc.	
	physician and Medical xaminer transit		233 Part / Enter the disease or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest. Approximate									Approximate	
		4 (1)	shock, or heart failure. List only one cause on each line.									Interval Between Onset and Death	
			disease or condition resulting in death)	Cardiac Due to (or as									
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uted.		Examiner	cause (Disease or injury that initiated events	Septice	mia	a							
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th cer	lendir r use	Z Z	IF FEMALE: 23b. Was decedent pregnant	of pregnanc		Ectopic pregnanc	:V	30		23d. Date of delivery Month Day Year			
dea	he at ed fo	Sici	in the past 12 months? 1 ☐ Yes 2 ☐ No		5 Other (specify)					Day Teal			
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es th	igned be de	Þ.	ratil. Other significant conditions contributing to death but not resolving in the diabetying dates given in act.									robably 4 💢 Unknown	
v requires t	sen s ould	ted								162 2	1 100 3 1	TODADIY 4 A OTHEROWIT	
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E e	ate h	Completed	1							performed? death? 1 □ Yes 2 🗓 No 1 □ Yes 2 □ No			
VILCIII	ctor,	Be	25. Was case referred to medical examiner?				1	26. Place of Dea	th (Check only	one)			
Physi	this c	ြို	1 ☐ Yes 2 X No				nt 3 □ DOA Oth	4 LI Nursing F			6 ☐ Other (Spe	ecify)	
19 P	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da		Bb. Time of Injury	Wor		28d. Describe	how inju	ry occurred		
Attending		cati	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could r					Yes 2 □No	DOS Location	(0)	(N	and Davids Manager	
or At		Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							28f. Location (Street and Number or Rural Route Number, City or Town, State)			
oital C												as stated	
Hos		Medical	(Check only 2 Medical one)	Examiner: On the basis of and manner st	of examinatio	n and/or in	vestigation, in my	opinion, death occi	urred at the time	e, date an	d place, and du	e to the cause(s)	
the		Mec	29b. Signature and title of cer f fier				29c. License number			29d. Date signed (Month, Day, Year)			
٩		_	Lorente -										
	V		,	(20) /T:					oril 21, 2009				
1	0,		30. Name and address person Fisehatsion G.	who completed cause of days.			,	enter Dr	ive Ro	ckwil	11e. Mai	ryland 20850	
	Sta	ato-	31. Date filed (Month, Day, Year)	32. Registr	ar's Signatur	'e		CHICEL DI.	LVC, IO	CIC V 1.		20050	
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DHMH 17 Rev 1/2001

ORIGINAL

1 - For State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month HE'RIL Year 21211219 **Physician** 06:30PM William Richard Walzog /Medical 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Center Towson Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 7 / 23 / 19 3 2 3 2 2 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral 1**XXM 2□ F MaryTand 218-28-5129 76 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Expriser must be retified at once. 1 □Yes 2No **Funeral Director** MD Baltimore Timonium 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Rhodes Place 67 21093 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No 14. Race - American Indian Black, White, etc. 1 XYes 2 No
If Yes, Give
Year or Dates: Korean 1 Never Married 2 Married 1 □Yes 2 No Specify: Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Sales Automotive 18. Mother's Name (First, Middle, Maiden Surname) Be (17. Father's Name (First, Middle, Last) Frederick Walzog Elizabeth Collings ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Jane Walzog/ Wife 67 Rhodes Place Timonium, Maryland 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 4/25/2009 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Timonium, Maryland Dulaney Valley Mem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility Towson, Maryland 21204 Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 6-8 WEEK **Physician** PNEUMONIA disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** SEPSIS 6-8 WEEK Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and mpletely filled in by the funeral director, page 2 should be detached for use as the buriat-transit mpletely filled in by the funeral director, page 2 should be detached for use as the buriat-transit ARTERIOSCLEROTIC CORONARY ARTERY DISEASE Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 🗌 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) examilier: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 □ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a. Certifier tix Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Light Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) my death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 2 29b. Signature and title 29d. Date signed (Month, Day, Year) 29c. License number 09 D60005 11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VANLANDINGHAM M. D DSLER DRIVE TOWSON MARYLAND 21204

Registrar DHMH 17 Rev 1/2001

State

BENJAMIN

31. Date filed (Month, Day, Year)

APR 24

Baltimore, Maryland 21215-0036

Box 68760,

P.O.

Division of Vital Records,

32 Registrar's Signatu

09-02997 Jamie White Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2009 13181

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Physician	/ 1.	Decedent's Name (Firs	t, Middle,Last)		w	HITE			Mon	of Death th Da I 15, 2009	y Yea		0127 hrs
cal Examine		JAMIE		street and number)			, Town, or L kersville	ocation of De			4c. County of		
Funeral		7922 McKaig Ro	er 6. Sex		e (In yrs. last birt	hday) If U	nder 1 Year oths Days	If Under 24			1980	g, Birthr Coun	olace (State or Foreign
Director	U	Sual Residence of Dece Da. State 10b.	edent	M 2 F	10c. City, Town	or Location							0d. Inside City Limits 1 Yes 2 No
ith the Maryland 23a or 28a-f show any notified at once.	Director	MD. Joe. Street and Number	MIKA	RICR IG RD	whike	10f.	LIP COUC	701		10g.	Citizen of W		ry?
's 'I'I' Second be filed within 72 hours after death with the Maryland aslut A should be filed within 72 hours after death and Mental Hygene. I waiting 'i' or items 23a or 28a-f sho tem 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at once traumatic event, the Medical Examiner	<u>e</u> 1	1. Marital Status Never Married	2 Married	12. Was Deceder Armed Forces	nt Ever in U.S.	13. Was Dec	ecify Cuban	, Mexican, Pi	? (Specify Yuerto Rican,	es or No- , etc.)	Whit	e, etc.	an Indian, Black,
2 hours after of "natural", o	≥ -	Widowed 5. Decedent's Educat Elementary/Seconda	tion (Specify or	If Yes, Give Year or Dates: Ily highest grade co College (1-4 o		Decedent's Us during most of	ual Occupat	ion (Give kin			6b. Kind of B	usiness/In	dustry
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es I and 2 should be filed within of Health and Mental Hygiene. If item 27 is marked other titer traumatic event, the Med	۵[19a. Informant's Name/ HARSH	Relationship (T	ype, Print)	17/18R) :	9b. Mailing Add 2279 e of Disposition	WEAT	HERBU	er or Rural F	: WAY	er, City or To	0.	40 2100
Pages 1 nent of H ant: If i		20a. Method of Disposi Burial 2 Donation 5	Other Specify	r	State Crem	atory or other p	ace)	s of Facility	MADN		71.5 111U	PUR	MO.
	- i	21. Signature of Funera 21. Signature of Funera 22. Signature of Funera 23. Part I. Enter the d	x - Pol	plications that caus	ed the death. Do	1101	YRT "	SOUTH	STER	COU 4	CK 111	0	Approximate Inter Between Onset a
hysician 'Medical taminer		failure. List only of Immediate Cause (Fin or condition resulting i	al disease a		shot Wound o								Death
	Examiner	Sequentially list condition if any, leading to immediate. Enter Underly (Disease or injury that	ediate ing Couce i initiated	Due to (or as a co									
e be executed ysician and burial - transit	ical Exa	events resulting in dea		AMENDED				-					7
D # ₹ 5	ician/Medical	IF FEMALE: 23b. Was decedent propast 12 months?		1 Live birt	nt at time of death	2 Fetal	death (3 Ectopio	pregnancy		23d, Date Mont	e of delive h	ry Day Ye ar
ords, P.O. Box 687 aw requires that the death certific thas been signed by the attending I 2 should be detached for use as the	by Physician/	1 Yes 2 No				ulting in the und	erlying caus	e giv e n in Pa	art I.		2 🗸 No	3 Pr	o the cause of death?
Cords, the law requires that been signed to 2 should be	Completed by									24a. Was autop perfo 1 ✓ Yes	rmed?	4b. Were a prior to death?	
IKE n: The riffcate or, pag	ပ္ပိ	25. Was case referre	d to medical				26.PI	ace of Death			Residence	6 2 00	nar: Scene
Of VITA ng Physicia After this cer	n: To Be			28a. Date of	patient	R/Outpatient 28b. Time of Inju 0114 hrs	ry 28c. I	Injury at Wor	_ Si		how injury o		let : Scene
Division of Vital Rec To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate h Completely filled in by the funeral director, page:	Certification:	1 Natural 2 Accident 3 Suicide	Pending Investig 6 Could r determine	jation 28e. Place	of Injury - At hon				atc 28	8f. Location (or Town, 322 McKaig	Street and N State) Road, Wa	lumber or Ikersville	Rural Route Number
the Hospita hin 24 hours the Funeral	Medical Cer			sician: To the besi	t of my knowledge of examination and		n, in my opii	filoff, death c	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	ue to the cau			tated. the cause(s) Month, Day, Year)
To with	Me	29b. Signature and	title of certifier	And marine; su	7)1	1)	29c. Lic	.C.M.E.	er		29d. Date	5, 2009	ivioritri, Day, rear)
7		30. Name and address	ess of person wander MD.	Assistant N	ledical Exam	iner 111	Penn Stre	eet, Baltin	nore, MD	21201			
	Stat	O. D. L. Stad (Man)		32. Re	egistrar's signatur	barker							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 8:00 A M 2009 IVICA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** burkville C Boultamore hesley Muenu If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min 215-05-9985 1 □ M 2 💢 F Months Days Hours 3 Dec 31,1915 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Mudical Event iner must be rediffed a Director 1 ☐ Yes 2 X No Maryland 10e. Street and Number itmore 10g. Citizen of What Country? 2123 de nited State Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. à Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any Injury or other traumatic event, Item Meonee. Elementary/Secondary (0-12) College (1-4or 5+) Bendix me Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mma ပ Dimms rederick 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Heaps Rd Andrew Campbell esuille MD 21132 20b. Place of Disposition (Name of cemetery, crematory or other place)

The Date 2009 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Chapita Cremation Services 8800 Hartord Parkville, MB Davas Rdi. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) stiv **Physician** /Medical Due to (or a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last NIC Due to (or as a consequence of) Examin To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit ompletely filled in by the funeral director, page 2 should be detached for use as the burial-transit sician and burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ₫ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1°Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 23109 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Har 12

State Registrar 31. Date filed (Month, Day,

Year)

DHMH 17 Rev 1/2001

gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** virainic DKI /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 7. Age (In yrs. last birthday) Year I if Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex Security Number **Funeral** Months Hours Days 1 □ M 2 Ø F Baitimore Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show Department of Health and Mental Hygiens (Linear) carer beautivity to the Health and Mental Hygiens (Linear 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examinat must be notified at once. 1 ☐Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 2 No Specify: () à 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) akc 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 109 H111 torest 4 ☐ Donation 5 ☐ Other (Specify) vans funeral chapel-22. Name and Addr Facility S chapel 21. Signature of Funeral Service License 16924 YORK Rd 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 4 ancinoma reementes disease or condition resulting in death) /Medical Due to (or as a sequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, led by the attending physician detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4 Pregnant at time of death 9 Unknown 5 Other (specify) 1 ☐Yes 2 No 9 Unknown cate has been signed by page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 1 ☐Yes 2 ☐No 1 ☐ Yes 2 No completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check onl one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 24 hours after death.

Funeral Director: After this 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Piace of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. within 2 the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Manshall A. Levine

31. Date filed (Month, Day, Year)

569

Registrar's Signature

North Charles Street

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Funera	al į	5. Social Security Number 6. Sex 213-33-1323	7. Age (In)	vrs. last birth	day) If Under 1 Year	If Under 24 Hrs Hours Min		rth	9. Birthpla	ace (State or Foreign
Directo	r	Usual Residence of Decedent	M 2□F 7!	5 Y	rs.		JUNET	6, 1933	UKKA	¥1 NE
arylane show	'n	10a. State 10b. County N/A	10c.	City, Town	or Location IORE				10	od. Inside City Limits 1 ☑ Yes 2 ☐ No
h the N r 28a-f n notifie	irect	10e. Street and Number			10f. Zip Code			10g. Citizen of \	What Count	
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To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 to		29a. Certifier 1 Certifying Phys	ician: To the best of my	knowledge,	death occurred at the ti	me, date and place	e, and due to the	e cause(s) and ma	anner as sta	ated.
the Hithin 24 the Filmplete	Medical	one) 29b. Signature and title of certifier	er: On the basis of exan and manner stated.	ilitation and	29c, Licens		urred at the time	29d. Date signe		
1		Matt,	M-b.		05	33 77		April 2	2,20	309
		30. Name and address of person who cor 2401 West Below 31. Date flied (Month, Day, Year)	npleted cause of death (Item 23a) (T	ype, Print) MAH	AJABIN	S. A	1, M.D.		
N S	itate	31. Date filed (Month, Day, Year)	39. Registrar's Si	ignature	more, we	12 2 1213	J			
Regis		ADD 2.4.2009	Beneva	B. A	acke					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Dav **Physician** SARAH **ADAMS** C. 12:30P M April 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Spring Montgomery Holy Cross Hospital <u>Silver</u> 8. Date of Birth OCt. 1, 1926 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2 🗗 F Maryland 578-36-3734 82 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State 28a-f show ir than "natural", or items 23a or 28a-f show the Modical Experience must be notified at 1 ☐ Yes 2 ☑ No Director MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3122 Fairland Road 20904 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify. ģ Specify: Black 3€ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation. 16b. Kind of Business/Industry within 72 (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within hand Mental Hygiene. 7 is marked other than? Elementary/Secondary (0-12) 9th College (1-4or 5+) Aide Veterinarian Hosp 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev George W. Jackson Effie M. Lee ပ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wilbur Adams (Son) 3122 Fairland Road, Silver Spring,MD 20904 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Injury or o 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Nat'l Mem.Park 4/11/09 MD Laurel, MD 4 Dopation 5 Other (Specify) 21. Signature of Funeral Pervice Licenses 22. Name and Address of Facility Snowden Funeral Home, PA 246 N. Washington St Rockville, MD20850 25a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Severe Peripheral Artery Disease /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Either Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): and Due to (or as a consequence of) Box 68760 attending physician for use as the buria the death certificate be 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2√2 No signed by the a o 9 Unknown 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 【XNo 3 ☐ Probably 4 ☐ Unknown General Debility Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 ☐Yes 2 ☐No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🔀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After thi 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Division of Vital Records, Hospital or Attending Physician: the Funeral Director: Af within 24 hor To the Fune completely fi ဂ္

> State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

Joselito D. Magday, M.D. 11701 Roby Avenue, Beltsville,MD 20705

and manner stated.

32. Redistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D013687

29d. Date signed (Month, Day, Year)

4/8/09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Sonia Ann Austin 7,2009 1:50 p.m^M. April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Linthicum Tate Hospice House If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🔽 F New York Director 220-74-2843 51 Jan. 17, 1958 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show "natural", or items 23a or 28a-f shov dical Evaminer must be notified at 1 ☐ Yes 2 V No Funeral Director Harwood Marvland Anne Arundel 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 4422 Cobalt Drive 20776 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian. 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No þ Specify: Specify: White 3 Widowed 4 Divorced Year or Dates: Completed of Health and Mental Hygiene.
item 27 is marked other than "natur
other traumatic event, the Madical 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Administrative Manager Telecommunications 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ Joseph Kleinman Pauline Etis ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4422 Cobalt Drive, Harwood, MD Carlton W. Austin/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot
once. to Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/10/09 Rockville, Maryland Parklawn Mem.Park 21. Signature of Funeral Service Dicensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1 Immediate Cause (Final disease or condition resulting in death) Cance **Physician** Lifeir /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 1 🗌 Yes 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an s certificate has b irector, page 2 s autopsy 1 ☐ Yes 2 this certifical 25. Was case referred to medical examiner? 26. Place of Death (Check only one ome 5 Residence 6 Other (Specify)
28d. Describe how injury occurred Other: 4 Nursing Home 5 Residence 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of D 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Affer 1 Natural 5 Pending 1 ☐Yes 2 ☐No 2 Accident investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

within 24 hours after death

To the Funeral Director:
completely filled in by the within 2

> State Registrar

29a. Certifier (Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) we/

32. Registrar's Signature

werner, MD

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number DS2830 29d. Date signed (Month, Day, Year)

stopte Road #300, Annapolis MDZ1401

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-02821 Jerry Anthony State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Physician/ Month Day April 8, 2009 1925 hrs Medical Examiner Anthony Richard Jerry 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Anne Arundel Annapolis Anne Arundel Medical Center 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or if Under 1 Year | If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Foreign CountryOhio Days Hours Months Director 06/25/1944 1 X M 2 64 287-38-6462 Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location any 10a. State 1 Yes 2 X No or items 23a or 28a-f show must be notified at once. MD Anne Arundel Crownsville Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21032 USA 211 Long Point Road 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status White, etc Armed Forces? Never Married 2 X Married Yes 2XX No White 2 X No Specify. specify: If Yes, Give Year hours after Widowed Divorced Yes traumatic event, the Medical Examiner "natural", à 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) L. Pages I and 2 should be filed within 72 I threat of Health and Mental Hygiene.
rtant: If item 27 is marked other than "
or other fraumatic event, the Medical E MD 21215-0036 Northrop Grumman 04 Engineer 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Anthony Jane Fe1kner Howard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 211 Long Point Road Crownsville, MD 21032 Marian Z. Anthony Spouse 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, Atlantic Crematory Burial 2 XCremation 3 Removal from State 4/10/09 Glen Burnie, MD Other Specify Donation 5 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Hardesty Funeral Home P.A.Gambrills, MD 21054 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease `xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and The law requires that the death certificate be executed Physician/Medical 23a,27 per me g892 6-11-09 vt physician a AMENDED X UNPENDED Box 68760. 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Month Day ned by the attending detached for use as t Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? signed by the detacher Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð No 3 Probably 4 ✔ Unknown Completed 24b. Were autopsy findings available 24a. Was an peen prior to completion of cause of autopsy death? s certificate has performed' No Yes 2 No 1 V Yes 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other₄ Hospital: 1 Residence 6 Other Inpatient 2 V ER/Outpatient 3 No

thin 24 hours after death.
thin 24 hours after death.
o the Funeral Director: After this certiff
mpletely filled in by the funeral director, Division of Vital Certification: Medical within 2.

1 ✓ Yes 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 27. Manner of Death 1 X Natural Yes 2 No Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) determined Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (kem 23a) Assistant Medical Examiner Theodore M. King, Jr., MD.

M.

111 Penn Street, Baltimore, MD 21201

O.C.M.E.

OCME

April 9, 2009

31. Date filed (Month Registra

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			For State	State o	of Marylan		rtment of F		nd Me		-	2000	1 1 3	100
_			State Registrar 1. Decedent's Name (First, Middle	lo (act)		Cei	lilicate of t	Dealii	2	Date of Dea	Reg. No.	2003	3. Time	of Death
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	Examin	er	Shady Grove Ad	, ,			Rockvi	11e			Mo	ntgome	ry	
Т	Funeral		Social Security Number	6. Sex	7. Age (In yrs. i	ast birthday)	If Under 1 Year Months Days	If Under 2	4 Hrs. 8. Min.	Date of Birl (Month, Da		9. Bir	thplace (State	or Foreign
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	the A	Director	MD Montg 10e. Street and Number	omery	Roc	kville	10f. Zip Code				10g. Citize	en of What Co	ountry?	
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	death	Funeral	11. Marital Status		edent Ever in U.	S. 13.\	Vas Decedent of H	lispanic Orig	jin? (Specif	fy Yes or No	- 1	4. Race - Ame Black, Whit		
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ַס	il Hyg other vent,	Be C	17. Father's Name (First, Middle,	Last)				18. Mother	's Name (F	irst, Middle,	Maiden S	Surname)		
<u>Ja</u>	uld be Menta Irked Itic ev	To E	Michael Randa					Luc	cy An	tico				
Maryland	2 sho and I is ma aume		19a. Informant's Name/Relations	ship (Type. Print)			g Address (Street							
``	and lealth m 27 her tr		William Balste	r (Son)			Four Sea			T		ation - City or		
Baltımore,	Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene. Inter if item 27 is marked other than "natural", or items 23a or 28a-f show into other traumatic event, the Medical Evan from a state or celling a stay or other traumatic event, the Medical Evan from a state or celling a		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 Removal from	State Gat	emetery, crer e Of I	sition (Name of patory or other plac leaven	ce) [April	15		•		_
Ħ	rtmer rtant:		4 Donation 5 Other (5		Cer	netery			2009	1 7		er Spr	ing, M).
Ba	permit. Page Department Important: If any injury or once.		21. Signature of Funeral Service	Sina ve)		Name and Addre						, MD.	20877
ı			23a. Part 1. Enter the disease, o	r complications that	caused the deat							100018	Approxim Interval B	ate
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687	ificate g phys	edical		0										
Box	death certific e attending p id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		utcome of pregna		Ectopic pregnanc	· V			2:	3d. Date of de		.,
	deat e att	sicia	In the past 12 months? 1 ☐ Yes 2 ĀNo		gnant at time of o		Other (specify)	, y				Month	Day	Year
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Ö	w requires t s been signe should be	Completed			-				_					
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ō	g Physer this eral di	n: To	27. Manner of Death	28a. Date	e of Injury	28b. Time o				d. Describe			ecny)	
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Division of Vital Records,	r Atte	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	minod Zoe. Flac	e of Injury - At ho	ome, farm, str	eet, factory, office		28	f. Location (City or To	Street and wn, State)	l Number or F	ural Route N	ımber,
<u> </u>	ital or At irs after o ral Direc lled in by													
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	To the within 2 To the complete	Med	29b. Signature and title of certific		nner stated.		29c. Licens	se number			29d. Date	e signed (Mon	th, Day, Year)	
	F > F 8		12/011	ne			645					18,2		
	10		30. Name and address of person	who completed car	use of death (Iter	n 23a) (Type.		,02			Whit	0, 2		
			Brian Carpente	r M.D. 99	01 Medi	cal Ce		re Roc	kvill	e, MD	. 208	50		
	Sta		31. Date filed (Month, Day, Year		Registrar's Signa									
	Registr	ar	71 N A	0	- Service - Service	La. 1.8								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1	For State Registrar	otato or marytana	•	rtificate of D	Death	Reg	N2001	9 3 8 9
	Physicia	an	1. Decedent's Name (First, Middle, Last)		EC (מב		2. Date of Death Month April 11	Day 2009 Ye	3. Time of Death
Á	/Medic Examin	al	4a. Facility Name (If not institution, give to 18028 Sand Wedge		ıed, i	4b. City, Town, or Hagerst		APILI II	4c. County of D	
	Funeral Director	7	5. Social Security Number 6. Sec			If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Young) July 11,1	ear)	Birthplace (State or Foreign Country) Iaryland
		7.	Usual Residence of Decedent 10a. State 10b. County Maryland Washingto		Town or L					10d. Inside City Limits 1 ☐ Yes 24☐ No
	with the M is or 28a-f t be notifie	Funeral Director	10e. Street and Number 18028 Sand Wedge I	rive		10f. Zip Code	1740	10g	. Citizen of Wha	t Country?
36	filed within 72 hours after death with the Maryland Hygiene. Uther than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	þ	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 【X No If Yes, Give Year or Dates:	3. 13.	Was Decedent of Hill Yes, specify Cuba		ecify Yes or No- Rican, etc.)		American Indian, White, etc. white
Maryland 21215-0036	within 72 hou ene. than "natura ne Medical E	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 1 2	cation e completed) College (1-4or 5+)	(Giv life.	edent's Usual Occupa e kind of work done o DO NOT use retired, tenance su	luring most of work)	king	b. Kind of Busin	
land 2	tal d d	To Be Co	17. Father's Name (First, Miodle, Last) Albert E.	Bartles			An	e (First, Middle, Ma na E.O. F	lamby	
, Mary	d 2 s th an 7 is trau		19a. Informant's Name/Relationship (T) Linda V. Bartles	wife	1802	ling Address (Street &		, Magerst	cown, Ma	ryland 21740
Baltimore,	permit. Pages 1 and Department of Healt Important: If Item 2 any Injury or other	5	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licegs	Removal from State Broa	adfor	consition (Name of ematory or other place Churce Come to 22. Name and Address	h ss of Facility	11 15, 2009 Ha Minnich Fu	igerstow ineral H	n, Maryland om, Maryland Iome Maryland 2174
	Physician and physician as the burial-transit	Aedical Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	b. Due to (or as a consequence) ence of):	nter the mode of dyin	g, such as cardiac	or respiratory arres	t,	Approximate Interval Between Onset and Death	
Вох	The law requires that the death certific the has been signed by the attending roags 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnar 1□Live birth 2□Fetal 4□Pregnant at time of de 9□Unknown	death 3	B □Ectopic pregnancy B □ Other (specify)			23d. Date of Month	
rds, P.O.	quires that t n signed by ald be detad	by	Part II. Other significant conditions co	ntributing to death but not resu	Iting in the	underlying cause give	en in Part I.	23e. Did toba		ute to the cause of death?
or Vital Records,	n: The law rec ficate has bee n, page 2 shou	Completed	25. Was case referred to medical				26 Place of Dec	24a. Was an autopsy perform	ed2 dea ZrNo 1 L	ere autopsy findings available or to completion of cause of ath?]Yes 2☐ No
Ž	Physician: r this certific ral director,	o Be	examiner?	Hospital: 1 ☐ Inpatient 2 ☐ I	ER/Outpati	ent 3 DOA Oth		10	ice 6 □Other	(Specify)
o u	ing Ph After th funeral	ion: T	27. Manuer of Death Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time Injury	/ Wor	yat k? Yes 2 ∐ No	28d. Describe how	v injury occurred	1
Division	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		me, farm,		100 2 110	28f. Location (Stre City or Town,		or Rural Route Number,
	the Hospital or hin 24 hours afte the Funeral Dir npletely filled in	Medical C	29a. Certifier (Check only one) Certifying Phy Medical Exam	ysician: To the best of my knowniner: On the basis of examination and manner stated.	wledge, de tion and/or	ath occurred at the til investigation, in my o	me, date and place opinion, death occu	e, and due to the cau urred at the time, da	use(s) and manr te and place, an	ner as stated. Indicate to the cause(s)
	To the To the compl	Me	29b. Signature and title of certifier			29c. Licens	e number	,		(Month, Day, Year)
	45	/		20	00-1/2	200	5579 661NBOTH		4-13	,-09
	15		Name and address of person who	Compus!	Rol	ste 13	1. (estuun	mDa	EYCIE
	St Regist	ate rar	31. Date filed (Month, Day, Year) APR 14 2	32. Fegistrar's Signa	ture.	par				

DHMH 17 Rev 1/2001

Box 68760 P.O. Division or Vital Records,

3altimore, Maryland 21215-0036

552 LEWIS STREET, HAVRE DE GRACE, MARYLAND 21078 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica completely filled in by the funeral director, p 28a. Date of Injury (Month, Day Year) Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 We certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (item 23a) (Type, Print) (NEA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 4 2009 Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of I	Marylan		artment o			d Menta		iene ()	09	13191
	Physici	an	Decedent's Name (First, Middle, L. Connie Linda	,						Mo	te of Deat	Day	Year	3. Time of Death
2	/Medio	cal	4a. Facility Name (If not institution, gi		ar)		4b. City, To	en or loc	ation of De		ril	12,	2009 unty of Death	9:00 a ^M
1	Examir	ıer	12616 Spickle		51)		Clea						shingt	on
	Funeral Director		216-48-6825	Sex 7. 1 □ M 2 ▼ F	Age (In yrs.	last birthday) Yrs.	If Under 1 Y Months D		Jnder 24 F ours N	Ain. 8. Da	te of Birth onth Day, -30-	1 9 4 7	9. Birthp Cour ML	place (State or Foreign htry)
	and w.		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	ecation						1	0d. Inside City Limits
	Mary -f ehc	tor	MD Washin	ngton	C]	lear S	Spring	ſ						1 ☐ Yes 2 ☐ No
	h with the 23a or 28a	ai Director	10e. Street and Number 12616 Spickle	er Road			10f. Zip Co	1722	2		1	0g. Citizen	of What Cour	ntry?
980	d within 72 hours after death with the Maryland Jiene. rthan "natural", or items 23a or 28a-f ehow I're Medical Exantine must be Lodilled at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	X_{N^0}		Was Deceden If Yes, specify 1 ☐ Yes 2 ☑		nic Origin? exican, Pu pecify:	? (Specify Your of the Rican,	es or No- etc.)		Race - Americ Black, White, ecify: Whi	etc.
21215-0036	within ene. than	Completed	15. Decedent's Especify only highest g. Elementary/Secondary (0-12) 12th grade		or 5+)	(Give	dent's Usual C kind of work o DO NOT use r omema k	fone during etired)	g most of	working			dence	•
Maryland 2	be file ital Hyg id othe event,	To Be C	17. Father's Name (First, Middle, Las			1	** **			Name (First		Maiden Sun	name)	
	ges 1 and 2 should to f Health and Mer if item 27 ie marke or other traumatic		19a. Informant's Name/Relationship Joseph Bond	(Type, Print) husband		126	16 Sp	ickl		Rd. C	lear	-	iwn, State, Zip Ting,	MD 21722
altimore,	Pages 1. nent of He ant: if iten ury or oth		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spec		ste Sm 1	Place of Dispo	sition (Name natory or ethe LLG CL	élilat	ory	4-14 2009			on - City or To Isburg	
Balt	permit. Page Department of Important: if any injury or post.		21. Signature Fun ral Service Lice	Hauley	R		Name and A Donald						ral H	ome, Inc
THE WINDS	Physician /Medical Examiner	ner	23a. Parl T. Enter the disease, or consheck, or heart failure. List ont Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying	aDue to (or	a a conseq as a conseq	uence of):	erek DV	TU	Dep	neu Vein	MS	m	sas)	Approximate Interval Between Onset and Death Instant
,8760,	certificate be executed nding physician and use as the burial-transit	dical Examine	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or	as Bonseq	uence of):	estere	ter	no					years
P.O. Box 6	death e atter	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		n 2∏Feta tat time of d	Ideath 3[Ectopic pregr Other (speci					23d.	Date of delive	ery Day Year
	wrequires thet the sbeen signed by th should be detache	۵	Part II. Other significant conditions	contributing to deat	h but not res	ulting in the u	nderlying caus	se given in	Part I.		3e. Did tot			he cause of death?
Vital Records,	The la ate hes pege 2	Completed									4a. Was a autops perforr ☐ Yes 2	y	4b. Were auto prior to co death? 1 \(\subseteq \text{Yes}	psy findings available mpletion of cause of 2 No
Vita	Physician: Th this certificate ral director, peg	Be	25. Was case referred to medical examiner?	Hospital:				Other		Death (Che	. /			
o	Attending Physic death. ctor: After this by the funeral di	tlon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of I (Month,		28b. Time o Injury		Injury at Work?	□ Nursin		1	ow injury od	Other (Specificurred	<i>y)</i>
Division	al or Attendi s after death. ii Director: A id in by the fu	Certification:	3 Suicide 6 Could not determine	289. Place of	Injury - At he , etc. (Specif	ome, farm, sto y)	reet, factory, o	ffice			cation (St ity or Town		umber or Rura	al Route Number,
	To the Hospital or Attending Physibin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edicai	(Check only one)	hynician: To the basi miner: On the basi and manner	s of examina	wledge deat	vestigation, in	he time, d my opinio	ate and pl n, death o	lace, and du occurred at the	ie to the m he time, d	auso(s) and ate and pla	dinamentas s ce, and due to	the cause(s)
,		M	29b. Signature and title of certifier	elf			29c. L	icense nur	mber 521-	36	2	9d. Date și	gned (Month,	Day, Year)
	H		30. Name and address therson who	completed cause	death (Iten	n 23a) (Type,	Print)	SPC	x+ N	no	21	79	5	
	Sta Registi		31. Date filed (Month, Day, Year) APR 1 4	32. B/9	istrar's Signa	ature.	had	(

09-03124 Makiah Bryant Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2009 13192

		For State				Cer	tificate o	f Death_					Reg. No.		T . =	(D. ath
Physicia		egistrar . Decedent's Nam	e (First, Midd	le,Last)								ate of Dea		Year		me of Death 350 hrs
dical Exami		Makiah	. Jei	ceam	Br	vant						nonth pril 19, 1				0001113
	4	la. Facility Name (f not institution	on, give s	treet and nu	imber)		4b. City, Town		ocation of D	Death			County of De	ath	
		Dorchester	General F	lospital	1			Cambrid	ge					rchester	Districts	- (5)-10-01
Funeral		5. Social Security N	Number	6. Sex		7. Age (In yrs. I	ast birthday)	If Under 1	_	If Under 2 Hours	24Hrs. 8. Min.	Date of B	irth(MM/D	D/YYYY) 9. For	reian	I .
Director		214-83-	0124	1 M	2 X F		Yr		Days 8	Hours	IVIII I.	09-1	1-20	008	Country)	Md.
	-	∠ 14-03- Usual Residence o														
iny		10a. State	10b. County			10c. City	Town or Loca	tion								Inside City Limits
- 0 m		Md.	Doi	che	ster		Cambri	.dge							1 4	Yes 2 No
Maryland 28a-f show any d at once.	흱	10e. Street and Nu	L					10f. Zip Co	de				10g. Citiz	en of What C	country?	
with the Maryland ms 23a or 28a-f sho be notified at once.	Director	702 Pi		- ~ ~ ~	+			21	613	3		ľ	USA	4		ì
ith the 23a o			ne so			cedent Ever in U	S 13 W	as Decedent			? (Specif	y Yes or N		14. Race - Ar	nerican li	ndian, Black,
items items	uneral	 Marital Status Never Marr 	ied 2 N	//arried	Armed F	orces?	15. If	Yes, specify C	uban,	Mexican, F	Puerto Rica	an, etc.)	1	White, etc	С.	1
r dea or it	큔				1 Yes Yes, Give Ye	2 No	1	Yes 2 🗶	No	snecify:				Specify:	Blac	rk
s afte	à.	3 Widowed 15. Decedent's E			or Dates:			ent's Usual Oc			nd of work	done	16b. K	ind of Busine		
hour matu Exan	pa.					1-4 or 5+)	during	most of workin	g life. I	DO NOT u	se retired)		1			
36 in 72 inan "	Completed	Elementary/Sec 0	oridary (0-12	'	College	1-010.7	I	infan	t				1			Ì
with with giene	E	17. Father's Name	/Eiret Middl	o Last)					1	8.Mother's	Name (Fi	rst, Middle	, Maiden	Surname)		
filed filed I Hyg ed of	- 1		•		-	. 1 1				Dwo		Phy	77.a	Brya	nt	
21215-0036 unld be filed within 7 Mental Hygiene. marked other than ic event, the Medica	o Be	Emerson 19a. Informant's N	on Le	erov	pe. Print)	ullen	19b. Maili	ng Address (Street	and Numb	er or Rura	al Route N	lumber, Ci	ty or Town, S	state, Zip	Code)
, MD 21215-0036 and 2 and a Monta of High within 72 hours after death with the Maryland early as house High within 72 hours after death with the Maryland early is marked of her than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at once	+					and Mother	100	6 Joh	ns	st.	. Sa	lisk	oury	Md.	2180	04
md 2 ealth		20a. Method of Di		vara	., -	20b	Place of Disp	osition (Name	of cem	netery,	D	ate	20c. l	ocation - Cit	y or Tow	n, State
St 1			Cremati	on 3	Removal	from State	crematory or	other place)	LL	C	0.4	27 (od D	21108	: [פת	aware
Pag ment tant:			5 Other			D1:	rect	remat	or	of Facility	- 04 Fenn	10 5	mit	Fun	era.	aware I Home
Baltimo permit. Page Department of Important: injury or otl		21. Signature of	Morel-Scrett	e Licenso	$^{\circ}$			524 R	ace	e St	C	ambi	rida	e.Md.	21	613
<u>ш</u> «Он.	_	23a. Part I. Enter	Sinte		>	TRIMP	th Do not ente								A	pproximate Interval
Physician		23a, Part I. Enter failure. List of	the disease, only one cau:						Jg,			,			E	Between Onset and Death
/Medical xaminer		Immediate Cause				ional as									-	
		or condition resul	ting in death	D	ue to (or as	a consequence	of):									
	_	Sequentially list of		b	Due to (or as	a consequence	of):									
	Examiner	if any, leading to cause. Enter Un-	derlying Caus	se _	70e to (o. a.	a concoquance										
-	aπ	(Disease or injury events resulting i			Due to (or as	a consequence	of):									
scuted and transit				d		23a,27	म्य न ्	SOUND.	-28	91 3/	27/0	9 11	_			
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760, ficate be g physici the buri	ĕ	IF FEMALE:			23c. If ye	s, outcome of pro	egnancy			ne-			23	d. Date of de	•	Year
587 rtific ling p		23b. Was decede past 12 mont		n the		e birth		Fetal death	3	Ectopic	pregnanc	СУ		Month	Day	real
Box 687 e death certiff the attending ed for use as 1	sician	1 Yes 2 ✔		Jnknown	17-	gnant at time of	death 5	Other (Specia	fy) _				1			
.O. Box 68 that the death certifued by the attending detached for use as	Phy	Part II. Other sig				known	t resulting in th	ne underlying (ause	given in Pa	art I.	23e. D	id tobacco	use contribu	te to the	cause of death?
P.O. ss that the gened by	J S	Part II. Other sig	Initicant con	aitions	CONTRIBUTING	g to death but no	it resulting in a	io undonymy i		3		1	Yes 2	✓ No 3	Probab	ly 4 Unknown
ords, P.O. w requires that as been signed b. should be deta		//										24a. W	vas an	1 24b. We	ere autop	sy findings available
rd; requ	ete											a	utopsy erformed?	pri	or to com ath?	pletion of cause of
tal Reco rian: The law certificate has		1			-								es 2	_	✓ Yes	2 No
R. Th	၂ ပိ	25. Was case re	ferred to med	ical				2	6.Place	e of Death	(Check or	niy one)				
Vital Rec ysician: The l his certificate l director, page	B B	examiner?	_		lospital:	Inpatient 2	✓ ER/Outpat	ient 3 D0)A	Other ₄	Nursing	Home 5	Resid	lence 6	Other:	
1 of Villing Physical After this	-	1 ✓ Yes 27. Manner of D	2 No		28a. Da	ate of Injury	28b. Time	of Injury 2		ury at Work	Ţ	28d. Desci	ibe how in	ijury occurred	hed	and large
n Cling	<u> </u>	1 Natural		ending		onth, Day,Year)	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	pprox am	1	Yes 2 X	No	ecree	n te	levisi	on	
IVISIOR or Attene after death Director:	g	2 X Accident	ı Ir	vestigation	28e P	4/19/09 lace of Injury - A			office	building, e	tc. 2	28f. Locati	on (Street	and Number	or Rural	Route Number, City St.
Division of Vital Records, pital or Attending Physician: The law require ours after death. After this certificate has been sirely in the thin certificate has been sirely in the thingent page 2 should be	Certification:	3 Suicide		ould not letermined	be	^{ify)} reside						or Tov Cambr	vn, State) :idge	, MD	The	51.
Di Hospital 24 hours : Funeral		4 Homicid	e		1000	best of my know		ccurred at the	time o	fate and pl				11111111111111	as stated	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the funeral Director: After this certificate has been signed by the attending physician and managed and independent of the physician and commetable filled in whe funeral director, nace 2 should be detached for use as the burial - transit	Medical	(Check only one) 2		g Physici Examiner	ian: To the r:On the bas	sis of examinatio	n and/or inves	tigation, in my	opinio	n, death of	ccurred at	the time,	date and p	lace, and du	e to the	cause(s)
To the within 2	led	29b. Signature a			and manne	er stated				se number				I. Date signe		
	≥	Z9b. Signature a		./	CR 0	0				.M.E.			Ar	oril 19, 20	09	
		a	rol	1	ul	Lan										
						cause of death (I		nn Street, E	Raltin	nore Mr	ጋ 212በ1	ı				
		Carol Alla				al Examiner			Januil	IIOIG, IVIL						
	Stat		APRY.2	2 20	109 32	Registrar's Sign	natur	ares								
Des	istra	72			- V-		A4 34									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2009 **Physician** ori areapy /Medical 4c. County of Death 4a. Facility Name (If not lastitution, give street and number) 4b. City, Town, or Location of Death Apt Examiner Germantown Harvest 5. Social Security Number Montgonery Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Hours **XX** M 2□ F Pennsylvania 41 02/27/1968 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it a Medical Examination of the model of the 1XYes 2 ☐ No Germantown Director MD Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with U.S.A. 20876 20404 Apple Harvest Circle Apt#0 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify:Black Baltimore, Maryland 21215-0036 1 □Yes 2 □No Specify: ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Aviation Boatswin Equipment Mate permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any Injury or other traumatic event, I's Mee. any Injury or other traumatic event, I's Me. Once. College (1-4or 5+) Elementary/Secondary (0-12) U. S. Navy BA 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Barbara Haythe Lawrence James Burns 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20404 Apple Harvest Circle #O; Germantown, Maryland 20876 Carla Y. Burns - Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington National Cemetery 04/13/2009 Arlington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Freeman Funeral Services 21. Signature of Huneral Service Licensee 4594 Beech Road; Temple Hills, Maryland 20748 Approximate
Interval Between
Onset and Death
The All S 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PANCREATIC TETASTATIC **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) 1 ☐Yes 2 ☐ No Division of Vital Records, P.O. s been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Ş</u> 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown EMBOLISM Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? s certificate has b lirector, page 2 st 1 ☐ Yes 2 🗆 No 1 ☐ Yes this certific al director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Medical Certification: To 28d. Describe how injury occurred funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death After t Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No NA NA 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number VILLGINIA VILLGINIA 0101058113 29b. Signature and title certifier

State

8901 WiscONSIN AVENUE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 2009 APRIL 1:40 P CHARLES G. BYNUM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ANNE ARUNDEL SOUTH RIVER HEALTH & REHAB EDGEWATER If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours NORTH CAROLINA 84 6 1924 Director 239-42-2933 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene. ant: If item 27 is marked other than "natural"; or Items 23a or 28a-f show unt: If item 27 is marked other than "natural"; or Items 28a or 28a-f show unt; or other traumaft event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1X Yes 2 □ No Director PRINCE GEORGE'S BOWIE 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 20716 USA 16010 EXCALIBUR ROAD APT A103 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. 1 XiYes 2 □ No NAVY If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No BLACK ģ Specify. 3 Widowed 4 □ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12TH ENGINEER/PLUMBER GOVERNMENT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CHARLES G. BYNUM SR. IVA STAFFORD ို 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16010 EXCALIBUR ROAD APT. A103 BOWIE, MARYLAND 20716 RUSSELL BUTLER/GRANDSON Ρ. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Important: If it any Injury or o once. 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State RIVERDALE CREMATORY 4/11/2009 RIVERDALE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 21. Signature of Europe Service Licensee 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caus, d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ne. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Squentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): physician ar the burial-t Physician/Medical IF FEMALE: yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) I ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 4 Unknown 3 Probably 1 TYes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☒ No 24a. Was an autopsy performed? Yes 2 No 1∐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 Other: 1 🔲 Inpatient ၀ 2 ☐ ER/Outpatient 3□ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, s after dean ral Director: Aftr within 24 hours aft

To the Funeral D

completely filled in

> 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) APR 1 3 2009 State Registrar DHMH 17 Rev 1/2001

Certification:

Medical

After

27. Manner of Death 1 Death 2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only

29b. Signature and title of

5 Pending investigation

6 Could not be

certifier

determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

28c. Injury at Work?

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License numbe

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month. Day.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 9, 2009 **Physician** Jr. 6:35 P M Samue1 Brown /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Ft. Washington Ft. Washington Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) July 6, 1943 Months Hours Days 1 17 KM 2 □ F Illinois 352-34-8094 65 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h. County 1 ☐ Yes 2 XXV Director Oxon Hill Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country USA 20745 7510 Catone Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ⊠Xes 2 □ No If Yes, Give Year or Dates: Vietnam 1 ☐ Never Married 21X Married 1 ☐ Yes 2/ No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Military U.S. Army 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hannah Taylor Mose Brown ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7510 Catone Court Oxon Hill, Maryland Jessie B. Brown / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/16/2009 Favetteville, North Carolina Cumberland Mem. Gardens Other (Specify) 4 □ Donation 22. Name and Address of Facility George P. Kalas Funeral Home P.A. 21. Signature 6160 Oxon Hill Road Oxon Hill, Maryland alas 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death WEEKS Immediate Cause (Final disease or condition resulting in death) METASTATIC LUNG CARCINOMA Due to (or as a consequence of) **EMPHYSEMA** years Sequentially list conditions, if any, leading to infriedrate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 □Yes 2 □No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 XXes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? yes 244No 1 ☐Yes 2 ☐ No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2XXNo 1XXInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred XX Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

Funeral

Director

28a-f show

23a or death with

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Physician /Medical

Examiner

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traumatic event, the Medical Examiner must be notified at

the Maryland

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

n 24 hours the Funeral Dire

State Registrar

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After

after death Director: d in by the f

within 2

29a. Certifier

Medical

death.

29b. Signature and title of certified MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Md Amir Mirza-Alikhani

and manner stated.

11711 Livingston Road Ft. Washington, Maryland

04/10/2009

29d. Date signed (Month, Day, Year)

20744

32. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

46046

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 04-10-2009 **Physician** 7:51 A M MINNIE M. BIRCKHEAD /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Adelphi HILL HAVEN NURSING HOME If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Days 82 212-26-7197 MD Director 07-05-1926 Usual Residence of Decedent 10c. City, Town or Location 10d. inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at XXYes 2 ☐ No Director Maryland Prince George's Adelphi 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 20783 USA 3210 Powder Mill Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ऒ No if Yes, Give Year or Dates: 14. Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed by 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) $\begin{array}{c} \text{Elementary/Secondary (0-12)} \\ 12 th \end{array}$ College (1-4or 5+) Housewife Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Emma Taylor George Kemp ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD 21202 10 N. Calvert Street Terry K. Sullivan/Guardian 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 04-14-2009 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State Riverdale, Maryland Riverdale Pk. Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mary Hadgman Cedar Hill FH 4111 PA Ave., Suitland, MD 20746 MO1374 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No ed by the a 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No Was an autopsy perform To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26 Place of Death (Check only one) Be Other: 4 Nursing Home 21 No Hospital ဥ 1 TYes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 28a. Date of Injury 28h. Time of 27. Manner of Death 28c. Injury at Work? Certification: (Month, Day Year) 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registra State

Registrar

DHMH 17 Rev 1/2001

State Registra
1. Decedent's

Certificate of Death

			1. Decedent's Nan	ne (First, Middle, Last)					2. Date of I		Day Year	3. Time of Death
	Physici		Frank .	A. Costantin	o, Sr.					April		2009	6:18a M
Constant .	/Medi Examir			(If not institution, give e of Greater				ity, Town, o	r Location of De	ath	4	4c. County of Dea	
	Funeral Director		5. Social Security I 579–22–87		X M 2□F	ge (In yrs. last birth 86 Y	Mont	der 1 Year hs Days	If Under 24 H Hours Mi		Birth Day, Yes 7, 19	9. Bi 923	rthplace (State or Foreign Country)
7	9		Usual Residence										
-	ryian	_	10a. State	10b. County		10c. City, Town							10d. Inside City Limits 1 ☐ Yes 2 🕅 No
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0-0	2 no	ted	/Cns	15. Decedent's Edu ecify only highest grad	ication	16a. [Decedent's U	Jsual Occup	nation	orkina	16b.	Kind of Busines	s/Industry
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	hysician /Medical		23a. Part 1. Enter shock, or he Immediate Cause disease or conditi resulting in death	ion	a, Pneum	line. nonia s a consequence of):		ng, such as card	liac or respiratory	arrest,		Approximate Interval Between Onset and Death
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Box 68760,	icate be executed physician and the burial-transit	ical Examiner	Cause (Disease o that initiated even resulting in death)	r injurÿ ts Last	Due to (or as	s a consequence of):						
~	9 6 5	Physician/Medical	IF FEMALE: 23b. Was decede in the past 1: 1 ☐ Yes 2 9 ☐ Unknow	2 months?		e of pregnancy 2 Fetal death at time of death	3 ☐ Ectop 5 ☐ Other	ic pregnand	су			23d. Date of d Month	elivery Day Year
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of Vital Records, P.O	rife faw requires cate has been signi page 2 should be	Completed by	Renal	Failure, At	rial Fibril	llation					topsy rformed	prior to death?	autopsy findings available o completion of cause of
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Division of Vita	s after death. Il Director: A	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e. Place of Ir building, e	njury - At home, farr etc. (Specify)	n, street, fac	tory, office	,	28f. Location City or 7			Rural Route Number,
	within 24 hours after To the Funeral Dire completely filled in b	Medical C	29a. Certifier (Check only one)	1 X Certifying Phy 2☐ Medical Exam									
5	within To th	Me	29b. Signature an	d title of certifier				29c. Licens	se number		29d.	Date signed (Mo	nth, Day, Year)
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	011			iress of person who c		death (Item 23a) (T		e MD	20852				

State Registrar 2009 32. Registrar's Signature B. Janes

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 9 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2335 Month APRIL 10 Mary Blossom Creighton 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death SIEK DORCHESTER GENERAL HOSPITAL CAMBRIDGE DORCHE 9. Birthplace (State or Foreign Country)
Maryland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, NOV • 9 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Hours Days Nov. 212-18-6881 86 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State 1 ☐ Yes 2 No MD Talbot Easton 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21601 6246 Waterloo Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 █No white Specify Specify: 3X Widowed 4 □ Divorced Year or Dates: Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) electronics supervisor 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ronald R. McGlaughlin Sr. Mabel Aaron 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rae F. Toms daughter 6246 Waterloo Drive, Easton, MD 21601 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Dorchester Mem. Park 4/15/09 Cambridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD Approximate
Interval Between
Onset and Death
AH HOUG 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Inharction disease or condition resulting in death) Due to (or es a consequence of): Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to or as a consequence of that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 □ Yes 2 No Month Year Day 5 Other (specify) 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 □Yes 1 TYes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred 27. Manner of Death 28a. Dete of Injury (Month, Day, Year) 28h. Time of 28c. Injury at Work? 5 Pending investigation 1 Natural 2 Accident 1 ☐Yes 2 ☐ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Box 68760. P.0. Records, of Vital Division

requires that the death certificate be executed physician and s the burial-trans attending p for use as use as signed by the a d be detached for has e 2 s page After this certificate funeral director, pag neral Director: A

Physician

/Medical

Examiner

Funeral

Director

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d 2 should be filed within 7 th and Mental Hygiene. 7 Is marked other than "

Department of Health a Important: If item 27 Is any injury or other tra

Physician

/Medical

Examiner

Examiner

Physician/Medical

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Completed

Be

Certification: To

Medical

29a. Certifier

(Check only one)

San

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Maryland 21215-0036

Baltimore,

Pages '

Director

Funeral

2

Completed

traumatic event, the Medical Examiner must be notified at

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely

State

29b. Signature and title of certifier

29c. License number 43238

JT.

f Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 11,2009

Cambridge,

The completed cause of death (Item 234) (Type, Print)

100 bramble

Registrar

State Registrar 31. Date filed (Month

DO

32. Registrar's Signature

100 Bramble Street Cambridge, MD 21613

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

nson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** lausser 2009 ANdrew /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Shock Center If Under 24 Hrs If Un 5. Social Security Number 8. Date of Birth (Month, Day, Year) Dec. 15,1936 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F Months Days Hours Mary land Dec. 72 220-34-8913 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Inportant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it e Medical Experimet Enrust be notified at once. 1 ☐ Yes 2 X No Directo Maryland Hurlock Dorchester 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21643 USA 3806 Wrights Wharf Road Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 12 Yes 2 No 195

If Yes, Give Year or Dates: 195 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1956-Baltimore, Maryland 21215-0036 $^{\prime\prime}$ 1 Never Married 2 Married 1 ☐ Yes 2 No 1958 Specify þ White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Power Plant Engineer City Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Reuben Andrew Clausser Bernice Adler ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3806 Wrights Wharf Road, Hurlock, MD 21643 Billie Ann Clausser/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 7 5 ☐ Other (Specify) East New Market Cem. 4/10/2009 East New Market, MD Name and Address of Facility Liler Funeral Home, P. O. Box 207 Of Main Street, East New Market, 21. Signature of Funeral Service MD 21631 23e. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** HARMINTION /Medical Due to (or as a consequence of): Examiner intra for eachy mel Bleed Left Hemis phere Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): attending physician for use as the buria P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No ed by the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 1 □Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be (26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical To the I within 2 and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

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31. Date filed (Month

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Year)

32. Registrar's Signature

Green St Baltimore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UU Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death April 9,2009 Year **Physician** Elizabeth Laura Cowan 1:18am M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 12102 Whiston Court Prince George's Bowie | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Day, Year) | 10-25-1918 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 X F Canada Yrs. Director 90 474-14-0396 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or Itama 23a or 28a-f ahow tre Medical Exeminer must be notified at 1 ☐ Yes 2 ☑ No Director MD Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12102 Whiston Court 20715 USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: þ Specify: White 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 5+ Town Librarian Librarian permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked oth any finity or other traumatic event 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Franklin Lloyd Darrell Elizabeth Laura Merrill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth C. Lyons/Daughter 12102 Whiston Court Bowie, MD 20715 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Bayview Crematory 4 Donation 5 Other (Specify) 4/10/2009 Baltimore, Maryland 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Service Licensee 6512 NW Crain Hwy. Bowie MD 20715 23a. Part1. Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Kenal Cell CarceR disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Dire to (or as a consequence of) Examiner ed by the attending physicien and detached for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed2 1 Yes 2 No 1 Yes 2 No or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Hospital: Other: 4 ☐ Nursing Home 5 Nesidence 6 ☐ Other (Specify) ၉ 1 ☐ Yes 2 🗹 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: tural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident completely filled in by the Director 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours efter To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

32. Registrar's Signature

29c. License number

Ruth

29d. Date signed (Month, Day, Year)

9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 7:45 PM ario claros 2009 mon /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore UMMC If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 M 2 □ F Honduras 05/21/1980 Director None Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10h County show ral", or items 23a or 28a-f show Examinat must be notified at 1XYes 2□No Director Rockville Md Montgomery the ! 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 13107 Evanston St. 20853 Honduras Funeral · death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☑ Never Married 2 ☐ Married Specify: Hispanic Baltimore, Maryland 21215-0036 1 XYes 2 No Specify: Honduras Completed by 3 Widowed 4 Divorced "natural" th and Mental Hygiene.

7 is marked other than "natur traumatic event, It o Medical. 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction 9th Labor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Maria Paz Del Cid Adrian Claros ೭ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13107 Evanston St. Rockville, Md 20853 item 27 i Osman Rene Claros/Brother 20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1
Department of H
Important: If ite
any injury or ot
once. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 04/17/09 Honduras General Cemeterv 4 ☐ Donation 5 ☐ Other (Specify) John T. Rhines Funeral Home atur of Funeral Service Licen 22. Name and Address of Facility 3005 12th St. NE Washington DC 20017 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Diff Physician coliti /Medical Due to (or as a consequence of): Examiner Acute lymphocytic Leukemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a contequence of): Exami Hospital or Attending Physician: The law requires that the death certificate be executed nding physician and ise as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Year Por Day 5 Other (specify) ed pe signed by the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has be irector, page 2 sl 2 🗆 No 2 **N**O 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA Medical Certification: To this 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide e Funeral 1 *Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. Greene St. Baltimore MD Sanoh 31. Date filed (Monti State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Codd 11:30 A^M Bridget Ann 2009 April 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Anne Arundel Arnold 657 Bay Green Drive If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Months Days Hours Min 1 □ M 2 🔀 F 53 July 2, 1955 577-76-5023 Florida Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No Anne Arundel Arnold MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21012 USA 657 Bay Green Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ZNo Specify: 3 - Widowed 4 - Divorced White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Guidance Counselor Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Karl Esther Suarez Young 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael J. Codd/Spouse 657 Bay Green Drive Arnold, MD 21012 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Bayview Crematory 4/10/2009 Baltimore, Maryland 4 ☐ Donation _ 5 ☐ Other (Specify) 21. Signature of Fundral Service Licensee 22. Name and Address of Facility Beall Funeral Home NW Crain Hwy. Bowie, MD 20715 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 No 23d, Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e, Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \sum Nursing Home Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 5 X Residence 6 ☐ Other (Specify) 28c. Injury at Work? 27. Manner of D. at 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transi Division of Vital Records, P.O. Box 68760 ending pluse as t for has been si e 2 should t certificate ha within 24 hours after death

To the Funeral Director:
completely filled in by the

Physician

/Medical

Examiner

Funeral

Director

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th and Mental Hygiene.
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permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau once.

Physician /Medical

Examiner

Director

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Physician/Medical

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Medical Certification: To

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only

29b. Signature and title of certifier

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

, 900 Bestacite Road #300, Annapolis, MD 21401 Werner, 18anine MO 31. Date filed (Month, Day, Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 04:12 AM April 8, 2009 Dickerson, Jr. J. Lloyd /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day,)
Oct. 14, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Year Hours Months 71 1937 Washington, DC 578-52-8951 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f show Hyattsville Maryland Prince George's 1 XYes 2 □ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ms 23a or death with 20784 United States 4837 - 67th Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 'natural", or items 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. African Pages 1 and 2 should be filed within 72 hours after a ment of Health and Mental Hygiene.
ant: I flem 27 is marked other than "natural", or ite among yor other traumatic event, Its Medical Estimatory or other traumatic event, Its Medical Estimatory. **1XX**Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married > Married 2 No Baltimore, Maryland 21215-0036 1 ∐Yes 2√CXNo Specify: ģ 3 Widowed 4 Divorced American Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 years Printer Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lloyd J. Dickserson, Sr. Mary L. Greene ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4837 - 67th Avenue Hyattsville, MD 20784 Edith Dickerson - Wife 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages Department of Important: If it any Injury or c 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Linocln Memorial Cemetery Apr 14, 2009 Suitland, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stewart Funeral Home, Inc. 4901 Benning Road, NE Washington, DC 20019 Approximate Interval Between Onset and Death 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and s the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed/ 1 □Yes 26. Place of Death (Check only one, 25. Was case referred to medical examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Nes 2 No Hospital: 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death Director: / d in by the f 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Funeral The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) hlifort State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Rosalie 5:06 A Derr April 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 12218 Big Pool Rd. Spring Washington Social Security Number 7. Age (In yrs. last birthday) If I Inde Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year) Months Days Hours Min 1 □ M 2 🖫 F 212-46-3452 June 20, Director 64 1944 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Expraision must be notified at once. Yes 2□No Director Maryland Washington Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 397 Coneflower Drive 21795 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify þ 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9 Telephone Manufacturer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jacob Drury ဂ္ Merle Gardner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12218 Big Pool Rd. Clear Spring, Maryland Sharon Hornbaker - Daughter 21722 Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Smithsburg Crematory April 13,2009 |Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) na re o Funeral & rvice Liver Eborned Admeriadity Home, P.A. 425 S. Conococheague St. Williamsport, MD 21795 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ancrea disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): requires that the death certificate be executed burial-transit Exami Due to (or as a consequence of): attending physician for use as the buria P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 ☐ Pregnant at time of death Day 5 Other (specify) detached 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate Division of Vital 1 ∐Yes 2 No 2 No Hospital or Attending Physician; director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral c 28a. Date of Injury (Month, Day, Year) After t 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural death. 2 Accident 1 ☐ Yes 2 ☐ No 24 hours after death Funeral Director: filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Lecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical npletely (Check only one) To the within 2. 29b. Signature and title certifier 29c. License number 29d. Date signed (Month, Day, Year) Marina 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Antictan St Hagers from MD 21740 JH-1 Shramatan ARRY 3275 31. Date filed (Month, Day, Year) 32. Registrar's Signature State **APR 13** Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year 9:10 a.M Ida Mildred Eby April 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 14434 Clear Spring Road Williamsport Washington If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2X F 214-42-2185 92 Director 1-18-1917 MDUsual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Health and Mental Hygiene. em 27 is marked other than "natural", or items 23a or 28a-f show wher traumatic event, the Madical Eventing runst bu natified at MD Washington Williamsport 1 ☐Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14434 Clear Spring Road 21722 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc Never Married 2 Married 1 □Yes 2 □ No Baltimore, Maryland 21215-0036 Specify. þ Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) residence 8th grade 0 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ John Eby Susan Emma Sollenberger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) care. permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tr once. Harold Williams giver 14434 Clear Spring Rd Williamsport MD 20b. Place of Disposition (Name of cemetery, crematory or other place)

Clear Spring MennoniteApril 13

Ceme tery 2009 20a. Method of Disposition 20c. Location - City or Town, State t Burial 2 ☐ Cremation 3 ☐ Removal from State Clear Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility PBoBaldaFdwil Thompson Funeral Home, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician congestive /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner spital or Attending Physician; The law requires that the death certificate be executed ours after death.

The law spital physician and reral birector; After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Year Day 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perforn 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? No. Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D0011266 April 9, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Howard N Weeks MD Northern Ave 580 Hagerstown, MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State **APR 14** Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar		State of	Maryla	and / Depa <i>Ce</i>		ent of F ate of 1			ental Hy	gien Reg. No	200:)	1320/
	Dhusisi		1. Decedent's Name (F	First, Middle, La	st)							2. Date of De				3. Time of Death
	Physici /Medic		Thomas E. I									April '	9, 2	009		2:05 AM
	Examin	er	4a. Facility Name (If no					4b. Cit	ty, Town, o	r Location	of Death		40	. County of De	ath	
			Atlantic Ge					Ber	_	If I Indi	r 04 Hra			orcest		
	Funeral Director		5. Social Security Number 232-38-7501		ex IXM 2□ F	7. Age (In y	rs. last birthday) Yrs.	Month	ler 1 Year s Days	Hours	er 24 Hrs. Min.	8. Date of Bit (Month, Da	th ay, Year,	9. 5	Country)	e (State or Foreign
			Usual Residence of De			,,						July 6	, 19	29 wes	ST V	irginia
	yland		10a. State 10	b. County		10c.	City, Town or Lo	cation							10d.	Inside City Limits
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	death with the Maryland ms 23a or 28a-f show	Director	10e. Street and Numbe	r				10f. Z	Zip Code				10g. Ci	itizen of What	Country	?
	th wi		58 Newport	Drive				21	811				U.S	.A.		
	r des	Funeral	11. Marital Status		12. Was Dece	ces?	i U.S. 13.	Was Dec If Yes, sp	edent of Hoecity Cuba	dispanic C an, Mexic	origin? (Spean, Puerto F	cify Yes or No Rican, etc.))-	14. Race - Ar Black, Wh		Indian,
36	s afte	by F	1 ☐ Never Married 3 ☐ Widowed 4 ☐		1 XYes If Yes, Giv	2 □ No e. 1 O 5 1	-1953	1 □Yes	2 🔼 No	Specif	y:				Whit	e
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ğ	al Hyg othe vent,	BeC	17. Father's Name (Firs	st, Middle, Last)						18. Mot	her's Name	(First, Middle				
<u>la</u>	uld be Menta Irked	일	Jesse Evans	3						Ber	natta	Evans				
Maryland 21215-0036	2 sho and is ma auma		19a. Informant's Name	/Relationship (Type. Print)		19b. Mailii	ng Addre	ss (Street	and Num	ber or Rurai	Route Numb	er, City	or Town, State	, Zip Co	de)
≥ .	and	3	Ruth Elnora		/ wife						0cean	Pines	, Ma	ryland	218	11
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "Actical Exercitive result by a citied at once.		20a. Method of Disposit		Removal from S	State 201	 Place of Disposition cernetery, crei 	sition (N natory or	lame of r other plac	ce)	Da	ate	20c. L	ocation - City	or Town,	State
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			23a. Part 1. Enter the d shock, or heart fa	ilure. List only	olications that ca one cause on ea	ich line.						respiratory a	rrest,		Int	proximate erval Between aset and Death
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	/Medical Examiner		roodking in deathy		Due to (d		quence of):									
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	rificate be executed by physician and as the burial-transit	Examiner	resulting in death) Last		Due to (c	or as a cons	equence of):	_								<u></u>
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00 %	death cerl e attendin d for use a	an/N	IF FEMALE: 23b. Was decedent pre		23c. If yes, outc	ome of pre	gnancy	TEatonio	pregnance	.,				23d. Date of c	lelivery	
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EVGNS,			29a. Certifier	Certifying Phy	slcian: To the l	best of my k	knowledge, deatl	n occurre	d at the tin	me, date a	l and place, a	nd due to the	cause(s	s) and manner	as state	ed.
32	the Ho hin 24 I the Fu npletel	Medical	(Check only 2 one)	Medical Exam	iner: On the ba and mann	sis of exam	ination and/or in	vestigatio	on, in my o	pinion, de	eath occurre	d at the time,	date an	d place, and d	ue to the	e cause(s)
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	00: 1		30. Name and address	of person who	ompleted cause	of death (I	tem 23a) (Type,	Print) _ /			· ·			Aprilz MD.		
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09-02427 Jerome Evrard

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2009 | 3208

		1- For State Registrar	·	Certifica	ate of De	ath			Re	eg. No.		
Physicia	ın/	Decedent's Name (First, Middle,Las						N	Date of Deat	th Day	Year	3. Time of Death 1528 hrs
ledical Exami	ner	Jerome D. 4a. Facility Name (if not institution, give	Evrard		4b. Cit	y, Town, or	Location of		larch 26,		nty of Death	
)		13043 Marquette Lane			l l	wie					e George	
Funeral		Social Security Number 6. Security Number	7. Age (In	yrs. last birth		Inder 1 Year		_	Date of Bir	th(MM/DD/Y	YYY) 9. Bir Foreig	rthplace (State or
Director		170-44-1711	M 2 F 5	7	Yrs. Mo	nths Days	Hours	Min.	05/1	0/1951	Co	ountry) PA
b		Usual Residence of Decedent 10a, State 10b, County	140-	. City, Town	as Logotion		<u> </u>					Land India City I with
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faryland 28a-f show Lat once.	ctor	10e. Street and Number			10f.	Zip Code			I 1	0g. Citizen of	What Cou	
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with t		11. Marital Status	12. Was Decedent Ever	r in U.S.	13. Was Dec							ican Indian, Black,
death or iten	Funeral	1 Never Married 2 Married	Armed Forces? 1 Yes 2 X	No	If Yes, sp	ecify Cuban,	, Mexican, F	Puerto Rica	an, etc.)	"	/hite, etc.	
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	B	John J. Evrard		- 1			Este1			ybitz		
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she tranmatic event, the Medical Examiner must be notified at once	٥	19a. Informant's Name/Relationship (T Henri deLozier/At	• • • • • • • • • • • • • • • • • • • •		. Mailing Addr							e, Zip Code) wie, MD20716
Baltimore, MD 2 permit. Pages 1 and 2 shoul Department of Health and N Important: If Iten 27 is m injury or other traumatic.		20a. Method of Disposition		20b. Place o	f Disposition (Name of cen		Da				Town, State
More Pages 1 tent of H unt: If i		1 Burial 2 X Cremation 3			ory or other pla Cremat		İ	4/3/2	009	 Waldo	orf. N	Maryland
Baltimore, permit. Pages 1 ar Department of Her Importaut: If ite		4 Donation 5 Other Specify 21 Signature of Funeral Service Licer		Hunce								ral Home,
E P P E		De fring					-			rie, Ma	-	nd 20715
Physician /Medical		23a. Part I. Enter the disease, or comp failure. List only one cause on ea	lications that caused the dich line.	death. Do no	t enter the mo	de of dying,	such as car	rdiac or res	piratory arre	est, shock, or	heart	Approximate Interval Between Onset and
yaminer			Hypertensive Ather		Cardiovas	cular Dis	ease					Death
,		Sequentially list conditions, b.	Due to (or as a conseque	nce or):								
	ner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conseque	nce of):								
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3760, ficate be executed g physician and s the burial - transi	n/Medical	UNPENDED	AMENDED									
68760, certificate be nding physic se as the bur	M/L	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of		Fetal dea	1th 3	Ectopic p	oregnancy		23d. Date Mont	e of delivery	y Day Year
Records, P.O. Box 687 The law requires that the death certific are has been signed by the attending, page 2 should be detached for use as t	sicial	past 12 months?	4 Pregnant at time				Lotopio	orogranoy		I VIOLE		July Tour
Box ne death control the attented for us	Phys	1 Yes 2 No 9 Unknowr	9 UIKIOWII						60- Bidd			
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COL law re has be	Completed								autop: perfor	sy		completion of cause of
tal Recition: The Lecturiticate Pector, page		25. Was case referred to medical				26 Filoso	of Death (C	Phonk only	1 Yes	2 No	1 🗸 Ye	es 2 No
Vital hysician: this certif	Be		fospital: 1 Inpatient	2 ER/Ou	utpatient 3		Othor:	Nursing Ho		Residence	6 Other	r: Scene
ion of Vital Records, tending Physician: The law requireath. for: After this certificate has been set the funeral director, page 2 should!	2	27. Manner of Death	28a. Date of Injury (Month, Day, Year)		Fime of Injury	28c. Injur	y at Work?			ow injury oc		
on tendii or: /	aţio	1 Natural 5 Pending 2 Accident Investigati				1_ Y	es 2 N	No				
Division tal or Attendi rs after death. al Director: A	Certification:	3 Suicide 6 Could not	be 28e. Place of Injury -	- At home, fa	rm, street, fact	ory, office bu	uilding, etc.	28f.	Location (S		mber or Ru	ıral Route Number, City
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To the within To the comple	Mec	29b. Signature and title of certifier	and manner stated.			29c. License						nth, Day, Year)
		Dury	inm			O.C.N	Л.E.			March 2	7, 2009	
	ł	30. Name and address of person who	completed cause of death	(Item 23a)						L		
2) /H	ل		Assistant Medical E			n Street,	Baltimor	e, MD 2	1201			
St Regist		31. Date filed (Month, Day, Year) APR 0 1 2	32. Registrar's Si	gnature .	par	1						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		amend 1 - State Registrar	#5 Perstile 69 W	Parylan	-		of Health of Deat			giene	11119	13209
		1. Decedent's Name (First, M	fiddle, Last)						2. Date of De			3. Time of Death
Physi		1/61116 (11) (4	ee Garst						Month April	Day	2009	7:13 P M
/Med Exam		And the address blacks of the sea to sale	ution, give street and number	7)		4b. City, To	own, or Location	on of Death	110111	4c.	County of Death	
LAGII			alescent and R	ehab.	Ctr.	C	rofton	1		A	nne Arur	ndel
Funera	al	5. Secial Security Number	6. Sex 7. A		last birthday)	If Under 1	Year If Unc	der 24 Hrs.	8. Date of Bir	th	9. Birth	place (State or Foreign intry)
Directo		54 1-14-0217	1⊠M 2□F	93	Yrs.	Months D	Days Hour	rs Min.	8. Date of Bir (Month, Da March	6,19	16 Kar	nsas
TQ.		Usual Residence of Deceden										
ylan how		10a. State 10b. Co	*	10c. Cit	y, Town or Lo							10d. Inside City Limits
a Ma	5	MD Anne	e Arundel			Cr	ofton					Yes 2 □ No
th th or 28	150	10e. Street and Number				10f. Zip Co				10g. Citi	zen of What Cou	•
23a	by Funeral Alrector	2131 Davidsor	nville Road			2	21114				USA	<i>A</i>
sms	9	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U	.S. 13.	Was Deceder	nt of Hispanic	Origin? (Specan, Puerto	ecify Yes or No Rican, etc.)	-	 Race - Amer Black, White 	
afte or it	ū	1 Never Married 2	If Voc Cive			1 Yes 218						nite
ural'.				1942-								
72 h	Completed	15. Dece (Specify only hi	edent's Education ighest grade completed)		(Give	dent's Usual (kind of work of DO NOT use	done durina m	nost of work	ing		nd of Business/li	
withir ne.	8	Elementary/Secondary (0-	12) College (1-4or	r 5+)		unicat				U.	S. Gove	mment
if it is 15-15-15-15-15-15-15-15-15-15-15-15-15-1			idle (ast)		COM	iuiiicat		other's Name	(First, Middle	Maiden	NASA Sumama)	
ntal hed of	a	3 34 6 1						Netti			alter	
Mal yidild KIK 12 should be filed within h and Mental Hygiene. 7 Is marked other then traumatic event, the M	F	19a. Informant's Name/Relat			10h Mailie	as Addraga (G					r Town, State, Zi	in Codo)
I E, INICAL INICAL INICAL STORMS After death with the Marylan I and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene. It has 23 or 28a-1 show Item 27 is marked other than "natural", or Itams 23a or 28a-1 show other traumatic event. The Medical Examinant har notified at			nnell/Daughter	-								e,MD 20721
Te, M 1 and 2 Health tem 27		20a. Method of Disposition	ileri/Daugitter		Place of Dispo	CONTRACTOR OF THE PARTY OF THE			Date		cation - City or T	
Definition Definition Department of I mportant: If It iny injury or or		1 ☐ Burial 2 ☑ Cremat	tion 3 Removal from State	9				1/10	/2009			Maryland
it. P.		`4 □Donation 5 □ Other		Bay	view C		OL y Address of Fa		-			Maryranu
permit. Pages 1 and Department of Healt Important: If Item 2 any injury or other			2						all Fun			
		23a Part 1 Enter the diseas	e, or amplications that cause	ed the deat			V Crain				D 20715	Approximate
		shock, or heart failure. Immediate Cause (Final	List only one cause on each	line.	11. DO 1100 OI11	1	J/	45 541 6145 (or reapmentary u	11030,		Interval Between Onset and Death
Physicia: /Medica	_	disease or condition resulting in death)	a	redu	ac	my	1/true	a				
Examine	_		Due to (or a	s a conseq	uence of):							
	a l	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or a	s a conseq	uence of):						_	
nsit	2	Cause, Enter Underlying Cause (Disease or injury	4									
be executed ician and burial-transit	Fyaminar	that initiated events resulting in death) Last	c. Due to (or a	s a conseq	uence of):							
ate be executed hysician and the burial-transit	100		d									
ificati g phy			u.									
nding use	2	IF FEMALE: 23b. Was decedent pregnan	23c. If yes, outcom							2	23d. Date of deliv	rery
death satte	0	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant			⊒Ectopic preg ∃Other (s <i>pec</i>					Month	Day Year
by the	ay d	9 □ Unknown	9□ Unknown									
s tha	hy Physician/Mad	Part II. Other significant con	nditions contributing to death		ulting in the u	nderlying cau	se given in Pa	art I.	23e. Did t	obacco u	se contribute to	the cause of death?
requires t			re to ITru	ue					1 🗆 '	Yes 2	□No 3□Pro	bably 4 Unknown
s bec	100	Deeu	oka						24a. Was		24b. Were aut	opsy findings available
The la	Completed									psy rmed? 2 No	death?	ompletion of cause of
iclan: sertifica ector, p	q	25. Was case referred to me	dical				26. Pla	ace of Death	(Check only o		- 10.103	22110
ysici ysici is ce direc	2	1 ☐ Yes 2 ZNo	Hospital: 1 ☐ Inpat	tient 2	ER/Outpatier	nt 3 DOA	Cther: 4	Nursing Ho	me 5 🗆 Resi	dence 6	Other (Spec	fy)
ig Phy ig Phy ier this	Ė		28a. Date of In (Month, D	jury lav Year)	28b. Time o Injury	f 28c	: Injury at Work?		28d. Describe			
tending leath, tor: Afte	40	1 Matural 5 Pe 2 Accident inv	vestigation (Month, 2	ay roar,	піјату	М	1 ☐ Yes 2	□No				
A Atte	1	3 ☐ Suicide 6 ☐ Co	ould not be stermined 28e. Place of In- building, 6	njury - At h	ome, farm, str	eet, factory, c	office		28f. Location (al Route Number,
s after on a selection of the selection	Cartifleation.		building, v	oto. 10,000	,,				,	,,		
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	lecipo		tifying Physician: To the bes	of examina	wledge, deat	h occurred at	the time, date	and place,	and due to the	cause(s)	and manner as	stated.
the H in 24 the F iplete	ipo		and manner s	stated.	orr arru/or In				tile tille,			
To To To To To To To To To To To To To T	8	29b. Signature and title of ce	rtifier			29c. l	License numbe	er			e signed (Month	
						1	D5702	28		00	1-08-0	09
moul		30 Name and address of per	rson who completed cause of	death (Iter	n 23a) (Type,			Λ				
4/14	1	Harrya Cha	spra M.V. (ello	KICIGE	19 AU	e.#23	of At	mayou	is ru	1D 214	tCj
S Regis	State strai	31. Date filed (Month, Day, Y	0 9 2009 32. Hadis	trar's Signa		back	,					

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

APR 09 2009

Registrar's Signatur

09-02637 Sandra Gaines Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009

		For State egistrar	Certifica	te of	Death			Reg. No.	har '	
Physiciar al Examin	1/ 1	Decedent's Name (First, Middle,Last) Sandra	Gaine				2. Date of D Month April 3,	2009 2009	Year	3. Time of Death 1148 hrs
	4	la. Facility Name (if not institution, give street and nun Fort Washington Hospital	nber)	41	b. City, Town, or L Fort Washing	gton		F	c. County of I Prince Ge	orge's
Funeral Director		5. Social Security Number 6. Sex 1 M 2XX F	7. Age (In yrs. last birth	nday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. April		Lo	B. Birthplace (State or oreign Country) Germany
_ ~ ~	Director	July July July July July July July July	2XX No	ingto		anic Origin Mexican, F			USA 14. Race - White,	American Indian, Black,
15-0036 filed within 72 hours aft Hygiene. d other than "natural" , the Medical Examine	Completed by	15. Decedent's Education (Specify only highest grad Elementary/Secondary (0-12) College (1-4+ 17. Father's Name (First, Middle, Last)	e completed) 16a. I	during mo	r's Usual Occupations of working life.	DO NOT us		Но	oward Ur	ness/Industry
21215-0036 and be filed within 7 Mental Hygiene. marked other than c event, the Medica	8	James W. Gaines Sr. 19a. Informant's Name/Relationship (Type, Print)	191	o. Mailing	Address (Street	and Numb	Elizabeth er or Rural Route	E.	Sikapa City or Town,	State, Zip Code)
and 2 sho lealth and item 27 is traumati		James W. Gaines Jr. / Brothe: 20a. Method of Disposition 1 Burial 2 XX Cremation 3 Remove from	20b. Place of	1301 of Dispos ory or oth	8 Salford ition (Name of center place)	Terrac	Date 4/12/2009	rlboro	. Location - C	land 20772 Sity or Town, State er, Maryland
Baltimore, permit. Pages 1 ar Department of He Important: If ite		4 Donaton 5 Other Specify: 21. Signature of Funeral Service Incensee		(5160 Oxon F	lill Ro	ad Oxon Hi	11, M	aryland	
Physician Medical ≟xaminer		or condition resulting in death) Due to (or as a Sequentially list conditions.	Thromboembolis consequence of):		ne mode of dying,	such as cal	rdiac or respiratory	rarrest, s	TIOCK, OF FIEST	t Approximate Interv Between Onset ar Death
ecuted and transit	al Examiner	(Disease or injury that initiated events resulting in death) Last d.	consequence of):							
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transit		23b. Was decedent pregnant in the	nant at time of death	2 Fe	etal death 3 ther (Specify)	Ectopic	pregnancy		23d. Date of (Month	delivery Day Year
P.O. es that the signed by be detach	Completed by Ph	Part II. Other significant conditions contributing t	o death but not resultin	ng in the	underlying cause (given in Par	24a.	Yes 2 Was an autopsy performed	24b. V	oute to the cause of death? Probably 4 Unknow Vere autopsy findings availarior to completion of cause ceath? Yes 2 No
I Re n: The tificate or, page	e Cor	25. Was case referred to medical			26.Place	e of Death (Check only one)	res 2	No 1	V res 2 No
Division of Vital Records, P.O To the Hospital or Attending Physician: The law requires that t within 24 hours after death To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detail	To B	27. Manner of Death 1 V Natural 5 Pending Investigation	n, Day,Yeár)	. Time of	Injury 28c. Inju	Other ₄ iry at Work Yes 2	No	ribe how	injury occurr	
Divis. Hospital or At 4 hours after d aluneral Direct sly filled in by	Il Certification:	3 Suicide 6 Could not be determined (Specify, 29a. Certifiler Continue Rhysician). To the he	st of my knowledge de	eath occi	urred at the time, d	ate and pla	or To	wn, State	and manner	er or Rural Route Number, (
To the Hospita within 24 hours To the Funeral completely fille	Medical	one) 2 Medical Examiner: On the basis and manner 29b. Signature and title of certifier What he had	of examination and/or stated.	investiga	ation, in my opinion	n, death oc	curred at the time,	date and	place, and d	ed (Month, Day, Year)
6		OLD Clark (14 At Day Verslands)	use of death (Item 23a) edical Examiner degistrar's Signar	111 F	Penn Street, E	Baltimore	e, MD 21201			
St Regis	tate trar	APR 1 3 2009 Can	Cyroliai o Sigilai ile	par	K)				OCME	
		10 0 10 0 0 0 0 0 0 0		DICINI	A I				UUIVIE	

ORIGINAL

10f. Zip Code

1 ☐ Yes 2X No

16a. Decedent's Usual Occupation

Colonel

20b. Place of Disposition (Name of cemetery, crematory or other place)

20688

Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify:

(Give kind of work done during most of working life. DO NOT use retired)

10c. City, Town or Location

Solomons 5

12. Was Decedent Ever in U.S. Armed Forces?

College (1-4or 5+)

1 Mayes 2 □ No If Yes, Give Year or Dates: WW II

iit. Pages 1 and 2 should be flied within 72 hours after death with the Maryland partment of Health and Mental Hygiene.

ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at Baltimore, Maryland 21215-0036

1 - For State Registrar

10a. State

MD

Director

Funeral

þ

Be

Usual Residence of Decedent

1 ☐ Never Married 2 ☐ Married

3 Widowed 4 □ Divorced

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

10

20a. Method of Disposition

10e. Street and Number

11. Marital Status

10b. County

Calvert

11750 Asbury Circle, Apt. #403

15. Decedent's Education (Specify only highest grade completed)

Charles William Hutcheson

1 ☐ Burial 2 X Cremation 3 ☐ Removal from State

Charles William Hutcheson (Son)

19a. Informant's Name/Relationship (Type. Print)

4 ☐ Donation 5 ☐ Other (Specify)

Physician

/Medical

Examiner

Funeral

Director

Balti	permit. Departn Importa any inju		21. Signature of Funeral Service Lice	nsee		and Address of Facility Ra O. Box 600, Lus		ral Home, P.A. and 20657		
	Physician /Medical Examiner		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the deat x, Do none cause on each line. a. Due to (or as a conse, bence of	plast	o, e of dying, such as cardiac	espiratory arrest,	Approximat Interval Bet Onset and		
Vital Records, P.O. Box 68760,	ate be executed hysician and the burial-transit	lical Examiner	So us field list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):							
	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and all director, page 2 should be detached for use as the burial-transit	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1							
		Completed by Ph	Part II. Other significant conditions	contributing to death but not resulting in	the underlying	cause given in Part I.		se contribute to the cause of on the cause of one of the cause of one of the cause		
ital	an: rtifica tor, p	Be C	25. Was case referred to medical			26. Place of Death (6	Check only one)			
	Physician: r this certifica ral director, p	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Ou	tpatient 3□ I	DOA Other: 4 Nursing Home	5 ☐ Residence 6	☐Other (Specify)		
Division or	or Attending Futer death. Director: After in by the funer.	Medical Certification: T	27. Mannor of Death 1 Natural 5 Pending 2 Accident investigation	(Month, Day Year) II	Time of njury M		d. Describe how injury			
			3 ☐ Suicide 6 ☐ Could not be determined		e, farm, street, factory, office 28f. Location (Street and Number or Rural Route City or Town, State)					
	ne Hospital n 24 hours a ne Funeral I	edical (29a. Certifier 1	nysician: To the best of my knowledge miner: On the basis of examination an and manner stated.	e, death occurre d/or investigati	ed at the time, date and place, an on, in my opinion, death occurred	d due to the cause(s)	and manner as stated. I place, and due to the cause(
•	To the within 2 To the Comple	Me	29b. Signature and title of certifier	ta Mb		29c. License number	1	e signed (Month, Day, Year) 1 10, 2009		
λ/	14 10 (11			completed cause of death (Item 23a)		Ci+0 2500 C	olomong M	[2008] 20688		

32. Registrar's Signature

23d. Date of delivery Month Day Year tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No ıs an opsy 2 No one) sidence 6 Other (Specify) e how injury occurred (Street and Number or Rural Route Number, Town, State) ne cause(s) and manner as stated. ne, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) April 10, 2009 Eric Berg MD 14090 Solomons Island Road, Suite 2500, Solomons, Maryland 20688

10d. Inside City Limits

10g. Citizen of What Country?

Specify:

18. Mother's Name (First, Middle, Maiden Surname)

5404 Summer Plains Drive, Mechanicsville, VA 23116

Rosa Sutton

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Date

Metropolitan Crematory 4/10/2009 Alexandria, Virginia

United States

16b. Kind of Business/Industry

20c. Location - City or Town, State

14. Race - American Indian,

White

United States Air Force

Black, White, etc.

1 ☐ Yes 2 No

State Registrar

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Margaret L. Harris 12:05 P.M April 9, 2009 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Calvert Memorial Hospital Prince Frederick Calvert If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) 1 □ M 2**X**□ F 08-05-1920 579-12-7157 88 Virginia Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2X No MD Calvert Solomons 5 4 1 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 11750 Asbury Circle, Apt. #232 20688 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 📉 No Specify: White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Housewife Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Miller Hattie Perry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 44866 Joy Chapel Road, Hollywood, Maryland 20636 Douglas A. Harris (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【**Cremation 3 ☐ Removal from State Metropolitan Crematory 4/10/09 Alexandria, Virginia 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Rausch Funeral Home, P.A. P. O. Box 600, Lusby, Maryland 20657 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 48 HOURS disease or condition resulting in death) Due to (or as a consequence of) 044 uentially list conditions, ny, leading to immediate se. Enter Underlying use (Disease or injury initiated events Due to (or as a consequence of) 3d. Date of delivery Month se contribute to the cause of death? 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If item 27 is marked other 1 any Injury or other traumatic event, the

Physician

Examiner

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

filed within 72 hours after death with the Maryland

3altimore, Maryland 21215-0036

/Medical

Director

Funeral

\$

Completed

Be

ပ

attending | for use as ours after death.

Jeral Director: After this certific filled in by the funeral director. Medical Certi

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Examiner	caus Caus that resu
ysician/Medical	IF F 23b.
Completed by Phys	Part
To Be C	25.
ication:	27. [

(Check only one)

29b. Signature and title of certifier

resulting in death) Last	Due to (or as a consequence of):					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)	23d. Date of delivery Month Day Year				
	ntributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death				
ATRIAL FIBA	ILLATON - FAILVRE TO	1 Yes 2 No 3 Probably 4 Unkr				
THRIVE	ILLATIN - FAILVRE TO	24a. Was an autopsy autopsy performed? 1 ☐ Yes 2 ☐ No				
25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	26. Place of Death (Hospital: 1 ☐ Hospitant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home	Check only one) e 5 ☐ Residence 6 ☐ Other (Specify)				
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		d. Describe how injury occurred				
3 ☐ Suicide 6 ☐ Could not be determined						
20g Cartifice 1 Partifying Phy	rejeion. To the heat of my knowledge, death accurred at the time, date and place or	ad due to the cause(s) and manner as stated				

dRV) 10

To the Hospital or Attending Physician:

e Funeral within 24 hor **To the Fune** completely fi

> State Registrar

FIGER BH Mid 31. Date filed (Month, Day, Year)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

REDERICK, MD-20

32. Registrans Signature ADR 10

2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year **Physician** Norma Messick Horwath 0135 0 2009 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner General HOSPITAI ambridge Dorchis If Under 1 Year | If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6 Sex **Funeral** Year) Months Days Hours 1 □ M 2 🔀 F 214-12-6567 March 5, 87 1922 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 72 hours after death with the Maryland 10a State 10h County 10c City Town or Location 28a-f shov 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at MD Dorchester Cambridge 1 ☐Yes 2 ☐No Director 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 5 Shady Drive 21613 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 □Yes 2ઁ No
If Yes, Give
Year or Dates; Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: white ģ 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) executive secretary government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be I and 2 should be filealth and Mental Raymond Willis Messick Elsie LeCompte ၀ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Connie Robinson sister 109 Linthicum Drive, Cambridge, MD Health 21613 other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 20a. Method of Disposition ÷ Department of In portant: If it a a is injury or o 1

Burial 2 □ Cremation 3 □ Removal from State Cambridge, MD Dorchester Mem. Park 4/14/09 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. - K.T. 700 Locust St., Cambridge, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final ercbial week **Physician** ascular accident disease or condition resulting in death) /Medical Due to (or as a conse un nce of): **Examiner** ti brillation Se quantally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed y physician and is the burial-tran-Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 □Yes 2 No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) s been signed by the should be detached 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an certificate has birector, page 2 sl autopsy performed? 1 □ Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Matural 2 ☐ Accident 5 ☐ Pending investigation Injury 1 □Yes 2 □No death. within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

APR 14 32. Registrar's Signature

DHMH 17 Rev 1/2001

atricia

31. Date filed (Month,

Cambridge MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend State of Maryland (Department of Jealth and Mental Hygiene

2009 | 32|5

		I- For State Registrar	m 28c per 1	Certifi	cate of	Death			R	eg. No.		
Physicia		Decedent's Name (First, Middle,La	st)						Date of Dea Month	ith Day Yea		3. Time of Death
ledical Exami	ner	Raphael Hayes					April 2, 2			009		0412 hrs
		4a. Facility Name (if not institution, gi			41	Charrents	Location o	f Death		4c. County of		e
		Prince Georges Hospital Center Cheverly Prince George's 5 Social Security Number 16 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8 Date of Birth (MM/DD/YYYY) 9 Birthplace (State or										
Funeral Director	- 1	5. Social Security Number 6. S		(In yrs. last t	oirtnday)	If Under 1 Yea Months Days				,	Foreign	
Director	L		X M 2 F	22	Yrs.				02/10/	1907	Coul	ntryMaryland
è.	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tov	wn or Locatio	n			-			10d. Inside City Limits
00 at										1 X Yes 2 No		
Maryland 28a-f show any d at once	홠	10e. Street and Number				10f. Zip Code			· · · · · · · · · · · · · · · · · · ·	10g. Citizen of Wi	hat Count	try?
215-0036 be filed within 72 hours after death with the Maryland nual Hygiene. rked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once.	Director	6203 Addison Road				20743				U.S.A.		
ith th		11. Marital Status	12. Was Decedent	Ever in U.S.	13. Was	Decedent of His	spanic Orig	in? (Spec	ify Yes or No	o- 14. Race	- Americ	an Indian, Black,
eath williems	Funeral	1 X Never Married 2 Marrie	Armed Forces?		If Ye	s, specify Cubar	, Mexican,	Puerto Rio	can, etc.)		e, etc.	
fler de		3 Widowed 4 Divorce	1 Yes 2	X No	1 1	Yes 2 X No	specify:			Specify:	Black	
5-0036 led within 72 hours afte Hygiene. other than "natural", the Medical Examiner	d b	15. Decedent's Education (Specify	only highest grade com	pleted) 16		s Usual Occupa st of working life				16b. Kind of Bu	usiness/In	ndustry
72 hc	e	Elementary/Secondary (0-12)	College (1-4 or 5	5+)			, DO NOT	use remed	,			ľ
03(vithin ene.	Completed		2 years		Su	ndent 						
15-C	Be	17. Father's Name (First, Middle, Las	st)				18.Mother			Maiden Surname	;)	
21215-0036 July be filed within 7 Mental Hygiene. marked other than ic event, the Medical		Ronald Hayes 19a. Informant's Name/Relationship	(Type Print)	- 71	19h Mailing	Address (Stree	at and Num		sa John	mber, City or Tow	vn. State.	Zin Code)
MD 21215-0036 d 2 should be filed within 72 hours after the and Mental Hygiene. m 27 is marked other than "natural", aumatic event, the Medical Examiner.	٩	Theresa Hayes - Mot		11						, Marylan		
≥ 5 d a a	-	20a. Method of Disposition			ce of Disposit	tion (Name of ce			Date -	20c. Location		
Baltimore, permit Pages I ar Department of Her Important: If ite		1 X Burial 2 Cremation 3			matory or other	er place) Cemetery		04/11	/2009	Clinton	. Mars	vland
Baltimo permit Page Department (Important: injury or otl	1	4 Donation 5 Other Special 21 Sun ture of Funeral Service Lice				_	s of Facility					
Ba Perm Injur	-	22. Name and Address of Facility Freeman Funeral Services 4594 Beech Road; Temple Hills, Maryland 20748										
Physician	\dashv	23a Fart I. Enter the disease, or con	nplications that caused	the death. Do	not enter th	e mode of dying	, such as c	ardiac or r	espiratory a	rrest, shock, or he	eart	Approximate Interval Between Onset and
Medical		Immediate Cause (Final disease	each line. _{a.} Gunshot Wound	ds (2) of H	ead and T	orso						Death
xaminer		or condition resulting in death)	Due to (or as a conse									
	iner	if any, leading to immediate	Due to (or as a conso	equence of):								
d sit	Examiner	(Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):										
760, Toate be executed sphysician and the burial - transit	Medical E		X AMENDED 2	8c, pe	r ME g	891 5/8	/09 1	T				
760, icate be g physici the buri	Med	IF FEMALE:	23c. If yes, outcor	me of pregnar	ncy					23d. Date of	of delivery	
687 ertific ding p		23b. Was decedent pregnant in the past 12 months?	1 Live birth	time of dooth			Ectopi	c pregnand	nancy Month Day Yea			Day Year
Box 68 death certifi he attending d for use as	Completed by Physician	1 Yes 2 No 9 Unknow	7	time of death	5 Oth	ner (Specify)						
O. B I the d by the		Part II. Other significant condition		h but not resu	ulting in the u	nderlying cause	given in Pa	art I.	23e. Did	tobacco use con	tribute to	the cause of death?
P.O es that the igned by the detac									1 _ Y	es 2 🗸 No 3	Prob	ably 4 Unknown
ords, w require s been si should b									24a. Wa			topsy findings available
COT law r has b									per	opsy formed?	death?	completion of cause of
tal Rec		- I	<u></u>			26 Place	o of Dogth	(Check or		2No	1 ✓ Ye	es 2 No
of Vital Records, rg Physician: The law require ther this certificate has been si neral director, page 2 should b	Be	25. Was case referred to medical examiner?	Hospital:	ent 2 🗸 El	R/Outpatient		Other -		Home 5	Residence 6	Other	
n of Vi ling Physi After this funeral di	٠ <u>۲</u>	1 Yes 2 No 27. Manner of Death	28a Date of Inju	ırv 2	8b. Time of Ir		NOWN	k? 2	8d. Describ	e how injury occu	rred	·
OD C tending eath. or: Af the fun	tion	1 Natural 5 Pending	(Month, Day,) Unknown	(ear)	JNKNOWN	1	Yes 2 X	No S	ubject sh	ot		
Division tall or Attendir rs after death.	fica	2 Accident Investig 3 Suicide 6 Could n	28e Place of Ir	njury - At hom	e, farm, stree	et, factory, office	building, e	etc. 2			ber or Ru	ral Route Number, City
Div pital or ours aft reral Di	Certification:	3 Suicide 6 Could not be determined (Specify) Unknown On Normal State (Specify) Unknown, Unk										
Hos 24 h Fun		29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)										
T the within To the comple	Medical	and manner stated. 29b. Signature and title of certifier					29c. License number				29d. Date signed (Month, Day, Year)	
	-	0 ~ 1.1					.M.E.			April 2, 20		
		30. Name and address of person who completed cause of death (Item 23a)										
3		Donna M. Vincenti, MD	Assistant Medi			Penn Stree	t, Baltim	ore, MD	21201			
	tate	31. Date filed (Month Day Year)	009 32 Registra	ar's Signature	par	الما						
Regis		11111	- January	<u>, u, </u>	7							
DHMH 17 Rev 1/2	2001	0044			ORIGINA	L						

Division of Vital Records, P.O. Box 68760,

/Medical Examiner or Attending Physiclan: The law requires that the death certificate be executed and the burial-tran physician attending p been signed by the should be detached cate has t certificate director. this funeral After ours after death. leral Director: Af filled in by the fur To the Hospital within 24 hours a To the Funeral completely

Funeral

Director

28a-f show

if than "natural", or items 23a or 28a-f show the Modeal Extra increase to notified at

death with the Maryland

filed within 72 hours after

permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygien. Important: If item 27 Is marked other tht. any injury or other traumatic event, In-1, once.

Physician

altimore, Maryland 21215-0036

1∐Yes 2	No	Hospital: 1 Inpatient 2 I	ER/Outpatient 3	3 🗆 D	OA Other: 4 Nursing F	Home 5 ☐ Re	sidence	6 Dother (Specify) Home	
27. Mapner of Deat Natural 2 ☐ Accident	h 5 ☐ Pending investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	м	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe	e how inji	ury occurred	
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injury - At he building, etc. (Specification)	ome, farm, street, fy)	factor	ry, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier					29c. License number		29d. Date signed (Month, Day, Year)		
▶ \/ 1	ut IX	- h.D			D28686		3	3-26-09	

1115 State

31. Date filed (Month, Day, Year) APR 01 32. Registrar's Signature

30. Name and address of person-who completed cause of death (Item 23a) (Type, Print)

1 av Nes

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Registrar

09-02758	
Bryant Howard	

ryant Howard		State of Maryland / Department of Health and Mental 1-For State Registrar Certificate of Death	Hygiene 2009 1321							
Physicia		1. Decedent's Name (First, Middle,Last)	Date of Death Time of Death							
Medical Examir		DIVAIL C. HOWAIL	April 7, 2009							
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of De								
		1508 Deep Gorge Court Oxon Hill	Prince George's							
Funeral	T	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Months Days Hours	Foreign							
Director		577-02-7643 1 X M 2 F 29 Yrs. Months Days Hours	07/07/1979 Country) DC							
		Usual Residence of Decedent								
v any		10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits							
and show	5	MD Oxon Hill	1 X Yes 2 No							
Maryland 28a-f show d at once.	Director	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?							
death with the Maryland or items 23a or 28a-f sho	ă	1508 Deep Gorge Court 20745	USA							
ms 23	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin?								
death or ite	Ĕ	1 Yes 2 X No								
		3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify:	Specify: Black							
nours Natur	Completed by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind during most of working life. DO NOT use								
16 n 72 l nan ",	iệ	Elementary/Secondary (0-12) College (1-4 or 5+)								
within iene.	Ĕ	12th grade Car Attendant	Private Name (First, Middle, Maiden Surname)							
215-0036 be filed within 72 hours after death with the Maryland mial Hygiene. rked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once	ပ္စု	unk								
MD 21215-0036 12 should be filed within 7 th and Mental Hygiene. 127 is marked other than madic event, the Medical	o Be		le Burley or or Rural Route Number, City or Town, State, Zip Code)							
MD 21 12 should th and Mer 177 is man	٩	, , , , , , , , , , , , , , , , , , , ,	Hyattsville, MD 20782							
	H	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date 20c. Location - City or Town, State							
Baltimore, bermit. Pages I an Department of Hea Important: If iter		1 X Burial 2 Cremation 3 Removal from State crematory or other place)								
timent trant:			4/15/2009 Landover, MD							
Sali Separ Injury			Marshall's Funeral Home							
	\dashv	23a. Pal I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardi	Washington DC 20011							
Physician		failure. List only one cause on each line.	Between Onset and Death							
xaminer		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):								
		h								
	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):								
	盲	cause. Enter Underlying Cause {Disasse or injury that initiated c								
ed ed	Exa	events resulting in death) Last Due to (or as a consequence of):								
be executed ician and urial - transit	dical Examiner	d. UNPENDED AMENDED								
	00 1		22d Date of delivery							
Sox 68760 leath certificate be attending physifor use as the bu	Physician/M	IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pr	23d. Date of delivery regnancy Month Day Year							
K 68	cia	past 12 months? 4 Pregnant at time of death 5 Other (Specify)								
Box e death c the atten ed for us	Ş	1 Yes 2 No 9 Unknown 9 Unknown								
that the ned by t detache										
P.C ires that signed t	d by		1 Yes 2 V No 3 Probably 4 Unknown							
ords,	Completed		24a. Was an autopsy indings available prior to completion of cause of							
e law e has ge 2 s	E D		performed? death? 1 Yes 2 No 1 Yes 2 No							
Vital Rec ysician: The I his certificate		25. Was case referred to medical 26.Place of Death (Cf.								
Fital sicial sicial	Be	examiner? Hospital: Inpatient 3 FR/Outpatient 3 DOA Other:	Nursing Home 5 Residence 6 V Other: Scene							
n of V ding Phy.	٦.	27 Mapper of Death 28a Date of Injury 28h Time of Injury 28c Injury at Work?	28d. Describe how injury occurred							
ion C tending eath. tor: Af the fun	Ö	1 Natural 5 Pending FOUND: 1 Yes 2 ✔ No.	Subject hanged self							
isic Atte er dea recto	icat	2 Accident Investigation Apr 7, 2009 0630 hrs 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City							
Division of Vital Records, P.O. sopital or Attending Physician: The law requires that the hours after death. Inneral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detailed.	ertification:	Suicide 6 Could not be determined (Specify) Single Family	or Town, State) 1508 Deep Gorge Court, Oxon Hill, MD							
id o a id	O	20a Certifier	e, and due to the cause(s) and manner as stated.							
To the Howithin 24 Particular Completely	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur	arred at the time, date and place, and due to the cause(s)							
5 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Mec	and manner stated. 29b. Signature and title of certifier 29c. License number	29d. Date signed (Month, Day, Year)							
		Canol LADORN O.C.M.E.	April 8, 2009							
		30. Name and address of person who completed cause of death (Item 23a)								
4		Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2	21201							
St	tate									
Regis										

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DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 6:13 CLAUDIA F. JONES 09 2009 APRIL /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HARFORD HAVRE DE GRACE HARFORD MEMORIAL HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, JUNE 2, 8 Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** 93 1 ☐ M 2 🔀 F Yrs. 246-38-5802 NORTH CAROLINA Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10c. City, Town or Location 28a-f show 1 Yes 2 □ No Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f sh any injury or other traumatic event, the Medical Examiner must be notified. once. **ABERDEEN** Director HARFORD MARYLAND 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number UNITED STATES 21001 796 EVERIST DRIVE Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 Specify: Specify: BLACK Completed by 3 ₩idowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 is and Mental Hygiene.
7 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE HOMES DOMESTIC 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be BARBARA (unknown) WILLIAM ARCH FULLER ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 796 EVERIST DRIVE, ABERDEEN, MARYLAND 21001 BARBARA L. GEORGE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 04/18/09 ABERDEEN, MARYLAND HARFORD MEMORIAL GRDS 22. Name and Address of Facility
LISA SCOTT FUNERAL HOME, P.A.
552 LEWIS STREET, HAVRE DE GRACE, MD 21078 21. Signature of Funeral Service Licensee 66 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 menths? 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has b autopsy performed2 2 [or Attending Physiclan: 25. Was case referred to medical examiner? 26. Place of Death (Check only one director, Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 No 2 ER/Outpatient 3 DOA ဥ 1 | Yes 1 Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

14

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Biowpo

32. Registrar's Signature

29c. License number

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 4-8-2009 **Physician** 10:06 AM MARJORIE SPAULDING **JONES** /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner PRINCE GEORGE BOWIE HEALTH CENTER BOWIE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 3-31-1920 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1 □ M 2 🛣 F Corintry, 490-26-2739 Yrs. Director Usual Residence of Decedent the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits 10b. County Itam 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic event, the Medical Examinar must be rediffed at 1√XYes 2□No Director PRINCE GEORGE BOWIE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 3312 DUNWOOD CROSSING DRIVE U.S.A. 20721 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📆 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene.

Is marked other than "natural", or Ite 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 🎇 Divorced BLACK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 YEARS SCHOOL TEACHER CHARLES COUNTY SCHOOLS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) HARRIET RIDLEY PEARSON SPAULDING 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 sinent of Health an ant: If Itam 27 is a WILLIAM R. SPAULDING-BROTHER 1905 RANDOLPH ST., N. E. WASH., DC 20018 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ŏ permit. Page Department of Important: if any injury or once. 4-10-09 LEE CREMATORY CLINTON, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility $PINCKNEY-SPANGLER\ F.\ H.$ mckney 524 - 8TH STREET, N. E. WASH., DC 20002-5236 23a. Part1. Enter the disease, or complications that caused the death. Do netenter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician METASTATI LUNG CANCER & LIVER MONTHS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Dav 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2√ No 9 ☐ Unknown X the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tes 2 No 3 Probably 4 Vunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has autopsy performed? 1 ☐ Yes 2 🙀 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No 10 To the Funeral Diractor: After the completely filled in by the funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 XNatural 5 Pending investigation М 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide within 24 hours a The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and tale of certifie 29c. License number 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAKESH ARORA, M. D. 14300 GALLANT FORREST LANE - BOWIE, MD 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Registrar

State

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

leverge, M.).

Registrar's Signatur

Daniel Alexander, M.D. 3001 Hospital Drive, Cheverly, Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 7:53 PM BARBARA ANN JORDAN 1 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Prince George's Hospital Center Cheverly If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Feb. 6, 1948 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 🕱 F 577-64-5481 Washington, DC Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f shov 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, The Medical Exercises, ust be a Milled M Capitol Heights Maryland | Prince George's Director 1 X Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20743 1305 Eastern Avenue Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ XNo 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 Yes 2 If Yes, Give Year or Dates: 72 hours after 1 Never Married 2 X Married African Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify þ 3 Widowed 4 Divorced American Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 7, and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Private 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 12 should be fii h and Mental F 7 is marked otl Be Emma Siler Hardy James ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is rr any injury or other traum once. Stanley L. Jordan (Husband) 1305 Eastern Ave., Capitol Heights, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 04/20/2009 | Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans 22. Name and Address of Facility Jordan Funeral Service, Inc 4001 Benning Rd., N.E., Washington, DC 20019 Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician 500 85 disease or condition resulting in death) ▲ /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine law requires that the death certificate be executed COAGULOPANY and the burial-trar Due to (or as a consequence of). Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No Month Day Year 5 Other (specify) ed by the detached P.O. 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an certificate has page 2 autopsy performed? director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral c 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Hospital or Attending 1 🔽 Natural Injury To the Hospital or Attendii within 24 hours after death.

To the Funeral Director: A

completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

32. Registrar's Signature

3001 HOSPITAL DRIVE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® 🗍 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Vear **Physician** Gloria Yvonne Jackson 9:09 A. M 2009 April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Hospital Center Cheverly Prince George's 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Hours Months Days 1 □ M 2 🖾 F Fairmount Hots. Director 215-36-7411 04/05/1938 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10b. County 28a-f show iral", or items 23a or 28a-f shov Examiner must be notified at 1 Yes 2 □ No Director Md. P.G. Capitol Heights 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with 610 Suffolk Avenue U.S.A. 20743 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after annot of Health and Mental Hygiene. 1₺ Never Married 2 Married African-American Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: <u>م</u> 3 ☐ Widowed 4 ☐ Divorced natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene important: If item 27 is marked other than "nature any injury or other traumatic event, the Medical once. 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) O.P.M. Elementary/Secondary (0-12) College (1-4or 5+) Equal Opportunity Specialist U.S. Government 2 yrs. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Jackson Evelyn Diggs ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Gerald Jackson/Brother 13309 Burleigh St., Upper Marlboro, Md. 20774 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Harmony Mem. Park 04/17/09 Landover, Maryland 22. Name and Address of Facility ington & Sons Co., Inc. of Funeral Service Licenses ans 4925 Burroughs Ave., N.E., Washington, D.C. 20019 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final reta tunes Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical the attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🗷 No Month Day Year 5 Other (specify) ed by the detached i 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an s certificate has b irector, page 2 sl autopsy performe 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft

To the Funeral Di

completely filled ir 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LIU 31. Date filed (Month, Day, Year)

APR 1 3 2009 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Month Time of Death Day Year 8:18 pM Dinorah Lopez-Molina April 06 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 □ M 2 🗷 F 412-40-2671 June 13. 1914 Puerto Rico Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 X No Silver Spring Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3112 Gracefield Road, #PV 107 20904 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 1∄ Yes 2 □ No If Yes, Give Year or Dates: WWII 14. Race - American Indian Black, White, etc. 1 X Never Married 2 ☐ Married 1 XYes 2 No Specify: 3 Widowed 4 Divorced Puerto Rican White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nutritionist **Health** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rafael Lopez-Molina Amalia Viade 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eva Souffront - Niece 1000 N.E. 14th Avenue, Apt. 501, Hallandale, Florida 33009 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🗷 Cremation 3 🗆 Removal from State 04/15/2009 4 Donation 5 ☐ Other (Specify) Fort Lincoln Crematory Brentwood, Maryland 21. Sign ture of Fune al Service Licens 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute Myocardial Infarction 1 day Due to (or as a consequence of):

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: filem 27 is marked other than "natural". ~ ... any Injury or other traumatic even.

physician and the burial-trans ending p use as 1 atter for u detached

Hospital or Attending Physician: The law requires that the death certificate be executed certificate has been s rector, page 2 should After this funeral of

Division of Vital Records, P.O. Box 68760,

John H.

31. Date filed (Month

within 24 ho

To the Fune

completely f

Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Extra Industry, if Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.			
ysician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown		ppic pregnancy er (specify)		23d. Date of delivery Month Day Year
	Part II. Other significant conditions of	contributing to death but not resulting in the underly	ing cause given in Part I.		use contribute to the cause of death? 2 No 3 Probably 4 Unknown
Completed by				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
Be	25. Was case referred to medical		26. Place of Death	(Check only one)	
0	examiner? 1 ☐ Yes 2 🔀 No	Hospital: 1 ♣ Inpatient 2 ☐ ER/Outpatient 3	□ DOA Other: 4 □ Nursing Hom	ne 5 🗆 Residence	6 ☐ Other (Specify)
Certification: T	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		Work?	8d. Describe how inji	ury occurred
Certific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		ctory, office 2	8f. Location (Street & City or Town, Sta	and Number or Rural Route Number, te)
Medical	29a. Certifier (Check only one) 1 ▼ Certifying Ph	nysician: To the best of my knowledge, death occuminer: On the basis of examination and/or investig and manner stated.	urred at the time, date and place, a ation, in my opinion, death occurre	and due to the cause and at the time, date a	(s) and manner as stated. and place, and due to the cause(s)
Ž	29b. Signature and title of certifier	/ / /	29c. License number	29d. D	ate signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar Stuckey, M.D., 3110 Gracefield Road, Silver Spring, Maryland 20904

32. Pegistrat's Signature

30. Name and address of person who completed cause of death (1)em 23a) (Type, Print)

D23649

April 7, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🕦 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day}009 April 7, **Physician** 11:00 PM Dea-Rita Bustamante Loberiza /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9708 Winery Court Gaithersburg Montgomery 8. Date of Birth (Month, Day, Ye Feb. 28, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days Hours Vear 1 □ M 2 🖼 F 216-76-8268 52 1957 Missouri Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the the discussion for a next to notified at Maryland Montgomery Gaithersburg 1 ☐Yes 2 X No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20878 United States 9708 Winery Court death v Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ★No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: þ 3 ☐ Widowed 4 😾 Divorced Asian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 72 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 5+ Accountant Accounting be filed w 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Fidela B. Bustamante Rufino B. Loberiza ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) .. Pages 1 and ... ment of Health an 9708 Winery Court, Gaithersburg, MD 20878 Rufino B. Loberiza (Father) 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date cametery, crematory or other place)
Metropolitan Department of Important: If it any injury or o 90 April 13, 4 ☐ Donation 5 ☐ Other (Specify) 2009 Alexandria, Virginia Crematory 21. Signature of Funeral Service 22. Name and Address of Facility DeVol Funeral Home, 10 East Deer Park Drive, Gaithersburg, MD 20877 23a. Part 1 chief the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock or near failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cardiovascular Respiratory Failure disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Diabetes Mellitus (Type II) Sequentially list conditions. Examine ri any, leading to immediate cause. Enter Underlying Cause (Disease or injury burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. physician sthe burial certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 X No Month Year 5 Other (specify) signed by the a o q | Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, þ Hypertension 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown should I Completed Hyperlipidemia 24a. Was an 24b. Were autopsy findings available prior to completion of cause of ak certificate has rector, page 2 a autopsy performed? death1 1 ☐ Yes 2 ☐ No 1 ∐Yes 2 👿 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 🛣 Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certification: Division 5 ☐ Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number April 9, 2009

State

31. Date filed (Month

cayada

30. Name an addres of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

Grace E. Sagayadan, M.D., 847-D Quince Orchard Blvd., Gaithersburg, MD 20878

D43358

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes and Open Areland Project Control of Health and Mental Hygienes and Open Areland Project Control of Health and Mental Hygienes and Open Areland Project Control of Health and Mental Hygienes and Open Areland Project Control of Health and Mental Hygienes and Open Areland Project Control of Health and Mental Hygienes and Open Areland Project Control of Health and Mental Hygienes and Open Areland Project Control of Health and Mental Hygienes and Open Areland Project Control of Health and Mental Hygienes and Open Areland Project Control of Health and Mental Hygienes and Open Areland Project Control of Health and Mental Hygienes and Open Areland Project Control of Health and Mental Hygienes and Open Areland Project Control of Health Areland Project

			For State Registrar	State of Ma	•	epartment of i Certificate of	Death	Reg.	2000	13221	
	Physicia /Medic		1. Decedent's Name (First, Middle, Last MELISSA FAYE LII) 2 	Date of Death	70 200 g	3. Time of Death 9:10 A M	
-	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of Death		4c. County of Death	1	
	Funeral Director		WASHINGTON COUI 5. Social Security Number 6. Se 213-63-5912 10	NTY HOSPI' × 7. Age IM 2∏F	FAL e (In yrs. last birthe 53 Yr	day) If Under 1 Year	HAGERSTOWN If Under 24 Hrs. 8 Hours Min. D	Date of Birth	9. Birtl	HINGTON Inplace (State or Foreign ARYLAND	
	pu 🔪		Usual Residence of Decedent 10a, State 10b, County		10c. City, Town of	r Location				10d. Inside City Limits	
	show	ō		INGTON	100. Oity, 10Will		GERSTOWN			1 □ Yes 2 □ No	
	28a-1	Director	10e. Street and Number	LIVOLOIV		10f. Zip Code	22.00.207121	10g	. Citizen of What Co	untry?	
	3a or		19511 THOMAS DRIVE				21740		U.S	S.A.	
	death	Funeral		12. Was Decedent I Armed Forces?	Ever in U.S.	13. Was Decedent of	Hispanic Origin? (Speci can, Mexican, Puerto Ric	fy Yes or No-	14. Race - Ame Black, White	rican Indian,	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modeal Eventinar must be neithed at once.	by Fu	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ Yes If Yes, Give Year or Dates:	No	1 □Yes 2 XNo		ou., o.o.,	Specify:	HTE	
5-0	72 ho 'natui	etec	15. Decedent's Edu (Specify only highest grad	cation e completed)	1 (ecedent's Usual Occu Give kind of work done	during most of working	16	b. Kind of Business/l	ndustry	
121	within ene. than	Completed by	Elementary/Secondary (0-12)	College (1-4or 5	+)	ife. DO NOT use retire FLO	OR AIDE		NURSING	G HOME	
d 2	2 should be filed within and Mental Hygiene. Is marked other than raumatic event, the M	Be Co	17. Father's Name (First, Middle, Last)				18. Mother's Name (/	First, Middle, Mai	iden Surname)		
Maryland	Ald be Alental riked of tic ev	5 B	IRA EUGENE HINES,	SR.			BETTY J.	STEVENS	5		
ary	and N s ma suma	_	19a. Informant's Name/Relationship (7)	rpe. Print)			t and Number or Rural I		-		
	1 and 2 Health tem 27 I		ROBERT R. LINK, HU	SBAND			DRIVE, HAG		, MD 2174		
Baltimore,	ges 1 If ite or ot		20a. Method of Disposition 1	Removal from State		risposition (Name of crematory or other pla			_	•	
ij	permit. Pages 1 Department of H Important: If ite any injury or ot once.	W	4 ☐ Donation 5 ☐ Other (Specify)		MANOR (CEMETERY	APRIL ess of FacilityBast—), MARYLAND	
Ba	permi Depa Impo any ir		21 Sign Collis	,			National Pi				
			23a. Part 1. Bater the disease, or comp	ications that caused	the death. Do no	t enter the mode of dy	ing, such as cardiac or I	respiratory arrest	t,	Approximate Interval Between	
	Physician	l y	shock, or heart fallure. List only o Immediate Cause (Final disease or condition			2 ANCER				Onset and Death	
	/Medical		resulting in death)		a consequence of					1000	
	Examiner	Sequentially list conditions, U Due to (or as a consequence of):									
	nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Uncerning Cause (Disease or injury that initiated events	Due to (or as	a consequence of						
ς,	execu in and ial-tra	Examiner	that initiated events resulting in death) Last	Due to (or as	a consequence of	:					
68760,	ficate be executed physician and s the burial-transit	edical		d							
	ertifica ing ph		IF FEMALE:	24,00							
O. Box	Physician: The law requires that the death certificate be executed riths certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burtal-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▶ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death	3 ☐ Ectopic pregnan 5 ☐ Other (specify)	cy		23d. Date of del Month	ivery Day Year	
σ,	w requires that the de been signed by the should be detached	by Ph	Part II. Other significant conditions co	ntributing to death b	ut not resulting in t	he underlying cause gi	ven in Part I.	23e. Did tobac	cco use contribute to	the cause of death?	
rds	en sig	ed b	·					1 □ Yes	2. No 3 □ Pr	obably 4 Unknown	
Records,	law re as be	Completed						24a. Was an autopsy	prior to	topsy findings available completion of cause of	
	: The cate h	Con						performe 1 □ Yes 2-2		2 □No	
of Vital	iclan certifi ector,	Be	25. Was case referred to medical examiner?	Hospital:		_ Tot	26. Place of Death (
o	Phys	5	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of Inju	ent 2 ER/Outp	atient 3 DOA	4 LI Nursing Home	e 5 Residence Id. Describe how	ce 6 ☐ Other (Spe injury occurred	cify)	
ion	nding tth. ". Afte e fune	ation	1. Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	y, Year) Inj	ury Wo	rk?]Yes 2 □No				
Division	l or Atter after des Director	Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injuding, et	ury - At home, farn c. <i>(Specify)</i>	n, street, factory, office	28	f. Location (Stree City or Town, S	et and Number or Ru State)	ural Route Number,	
	To the Hospital or Attending Physician: The law within 24 hours after death. 3o the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical C			f examination and		time, date and place, ar opinion, death occurred				
	To the within 2 To the comple	Me	29b. Signature and title of certifier	1		29c. Licer	se number	29d	I. Date signed (Mont	h, Day, Year)	
	128		1 Southla	la n	10	D 47	5813	A	PRIL 10	,2009	
	10		30. Name and address of person who c	V							
	, -		SCUT WEENERM			PUS RO STE	100 HAGEN	ISTOWN, M	nD 21742		
	Sta Registr		31. Date filed (Month, Day, Year)	09 32, registr	ar's Signature	part					

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Vear **Physician** Rita Carolyn Mayse 12:57aM April 9. 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 9502 Buck Lodge Court Hyattsville Prince George's If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 1 □ M 2 🗓 F 579-42-7555 80 February 15, 1929 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, I's "Modes! Exprement mat be mutilled at 1 ∏Yes 217 No Director Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? within 72 hours after death with 9502 Buck Lodge Court 20783 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐Yes 2 🔀 If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 2 X No 3altimore, Maryland 21215-0036 1 □Yes 2X No Specify. White Specify: <u>ک</u> 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 12 should be filed within 7 in and Mental Hygiene. 7 is marked other than "! Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Martin Caspar Marie Frances Howard ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health as
Important: If item 27 is
any injury or other trau Donald Mayse / Husband 9502 Buck Lodge Court, Hyattsville, MD 20783 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 💢 Burial 2 □ Cremation 3 □ Removal from State Silver Spring, MD Gate of Heaven Cemetery April 14, 2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. West, Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Chronic Respiratory Failure Years Physician /Medical Due to (or as a consequence of): Examiner Late Effects of Tuberculosis Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examir law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Box 68760, physician the burial Physician/Medical attending pl for use as t IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) P.0. detached 9 I Unknown signed by I I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 Dementia 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown cate has been si page 2 should b Completed History of Breast Cancer 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performe certificate 1 ∐Yes 2 X No 1 ☐ Yes 2 🛛 No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Yes 2√XNo 1 Inpatient 2 ER/Outpatient 3 DOA မှ funeral 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 🕅 Natural 5 ☐ Pending investigation To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D32033 April 9, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Peter G. Hamm M.D. 5530 Wisconsin Avenue, Chevy Chase, MD 20815 State park Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Physicia /Medic Examin

Funeral

Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amportant: If item 27 is marked other than "natural", or items 23a or 28a-f show amportant: It item 27 is marked other than "natural", or items 23a or 28a-f show amount injury or other traumatic event, it is Midical Every at a usual parable page.

Baltimore, Maryland 21215-0036 Physician

/Medical Examiner

MACTINEZ,

To the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transi Division of Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s

State Registrar

	1 - State Registrar	Certificate of Death						Reg. No 2009 1322				
	1. Decedent's Name (First, Middle, Last)					2. Date of Dea	ath Da	.,	Year	3. Time of Death	-	
in al	Jose Alberto Martine	2 Z				APKIL	7		209	2:36.4 M		
er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location	of Death		4c.	County	of Death			
	Doctor's Community Hospital	_	Lanha	am					ce Ge	eorge's		
	5. Social Security Number 6. Sex 7. Age (In yrs. last)		If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da	th v, Year)		Count	ace (State or Foreign		
	none ¹™ 2□F 47	Yrs.				12/25	/19	61	El S	älvador	_	
	Usual Residence of Decedent 10a. State 10b. County 10c. City, To	wn or Lo	cation						T10	d. Inside City Limits	_	
ctor	MD Prince George's Ne	w C	arrollto	5n						1 □Yes 2 X No		
To Be Completed by Funeral Director	10e. Street and Number 57!0 84th Avenue	10f. Zip Code 20784						10g. Citizen of What Country? El Salvador				
ner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. \	Was Decedent of Hi f Yes, specify Cuba	spanic Or	igin? (Spe	ecify Yes or No	-		e - America k, White, e			
by Fu	1 □ Never Married 232 Married 1 □ Yes 2 237No 1 □ Yes 2 237No 1 f Yes, Give 3 □ Widowed 4 □ Divorced Year or Dates:	1	Yes 2□No El Sal	Specify:		r nourt, oto.,		Specify		ite		
ted		Sa. Deced	dent's Usual Occupa	ation		. 1	16b. K	ind of Bu	siness/Ind		-	
ble	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	life. L	kind of work done d DO NOT use retired,)		ing						
E O	1 2	Pai	nt Cont	ract	or		Pa	int	Co.			
o Be C	17. Father's Name (First, Middle, Last) unobtainable					e (First, Middle, Martin		Surnam	e)			
Ĕ	19a. Informant's Name/Relationship (Type. Print) Wife 1	9b. Mailin	ig Address (Street a	and Numb	er or Rura	al Route Numbe	er, City o	or Town,	State, Zip	Code)		
	Lucila Isabel Medrano de Mai	ctin	ez 5/10	84t	h A	ve.New	Ca	rro.	Litor	1,Md20784	ł	
	20a. Method of Disposition 20b. Place ceme	of Dispo	sition (Name of natory or other place	e)		Date			City or Tov			
	1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify)	esap	eáke Cr	em 4	/09,	/2009	Be	lts	zille	∍,Md		
	21. Signatur of Frequency Service Lifeties		Nemr pd Addres 41 Colum							P.3. Md20910		
_	23a. Part1. Enter the disease, or complications that caused the death. D shock, or heart fellure. List only one cause, n each line.							Opi		Approximate		
	shock, or heart failure. List only one cause on each line.		Interval Between Onset and Death									
	disease or condition resulting in death)	1	in	27)				-		_	
	Die to for as a consequence	Die to for as a consequence of the following										
ē	Sequentially list conditions if any, leading to immediate b. Due to (or as a consequence oi):										_	
/Medical Examiner	cause. Enter Underlying Cause (Disease or injury	1-11	stone	2/	6	1001	Xi	m	0			
xar	that initiated events resulting in death) Last Due to (or as a consequence	e of):	<i>>) \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ </i>			1		-7	7		-	
<u>a</u>	Acut	3	Len	al)	fai i	/11	10	>			
ğ	d				V	, ,	00				_	
Ž	IF FEMALE: 23c. If yes, outcome of pregnancy							23d Dat	e of delive	rv		
ciar	in the past 12 months?	ath 3⊑ 5□	Ectopic pregnancy Other (specify)	/				Mo		Day Year		
ıysi	1 □Yes 2 □No 9 □ Unknown		2 0 (110) (0,000)/									
7	Part II. Other significant conditions contributing to death but not resulting	in the ur	nderlying cause give	en in Part I		23e. Did to	obacco i	use contr	ibute to the	e cause of death?		
Be Completed by Physician	Palemonia.					1 🗆 1	Yes 2	No	3 ☐ Proba	ably 4 🗌 Unknown		
ete	Coapul 1060 the	1				24a. Was	an	24b. V	Vere autor	sy findings available		
μŽ		1				autor perfo	osy rmed?_	1 5	prior to con death?	pletion of cause of		
ပ္	25. Was case referred to medical			OC Disc	o of Dootl		2 12/No) 1	□Yes	2 ∐ No	_	
	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/	Outnotion	ot all DOA Othe	or:		h <i>(Check only o</i> me 5 ☐ Resid		c 🗆 🗆	an /O		-	
Ĕ	27. Manner of Death 28a, Date of Injury 28b	. Time of	IL SELECT	4 🗆 🕦		28d. Describe				<u> </u>	-	
ţ	1 Matural 5 □ Pending (Month, Ďay, Year) 2 □ Accident investigation	Injury		(? Yes 2 🗖	No							
fica	3 Suicide 6 Could not be 28e, Place of Injury - At home,	farm, stre	eet, factory, office			28f. Location (S	Street ar	nd Numb	er or Rural	Route Number,		
ert	4 Homicide determined building, etc. (Specify)					City or Tov	wn, State	9)				
Medical Certification: To	29a. Certifier (Check only (Ch										-	
Medi	one) and manner stated. 29b. Signature for of certifier		29c. License								_	
_	200 Ciglian Colonia Co		D 56	2/,/.			29d. Date signed (Month, Day, Year)					
	Major 1		WJ0	44 K	0		09	10.	17	2007	_	
	30. Name and address of person who completed cause of death (Item 23)	Type,	Print) Q1/Q	6-	× / •	CK ROA	/	/ . /	/	21 222		
e.	31. Date filed (Month, Day, Year) 32. Registrar's Signature	,	1 =	G (O)	JLU	UK NO.4	to (LAW,	HAM.	M D 8010/	-	
ar	APR 10 2009 Jeneur	9. 1	backer									

			For State Registrar	State of Maryl		irtment of H tificate of L			ene∠ U : g. No.	09 13230
Ī	Physicia	ın	1. Decedent's Name (First, Middle, Las	e MCSHERRY				2. Date of Death Month April 1		Year 1.55 A M.
*	/Medic Examin		4a. Facility Name (If not institution, given 106 Southern Oak	e street and number)			Location of Death	1192201	4c. County o	f Death
	Funeral Director		5. Social Security Number 6. S		yrs. last birthday) 82 Yrs.	Hagerst If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Nov. 5,	1.	9. Birthplace (State or Foreign Country) Maryland
<u>`</u>	D .	or	Usual Residence of Decedent 10a. State 10b. County Maryland Washingt		. City, Town or Lor agerstow					10d. Inside City Limits 1
	h with the l	al Director	10e. Street and Number 106 Southern Oak	Drive		10f. Zip Code 21740)	10	og. Citizen of WI	· ·
336	be filed within 72 hours after death with the Maryland ttal Hyglene. do other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 【※ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever i Armed Forces? 1 ☐ Yes 2 █️No If Yes, Give Year or Dates:		Was Decedent of Hi f Yes, specify Cuba I □ Yes 2⊠No	spanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		- American Indian, , White, etc. white
21215-0036	within ene. than "	Be Completed	15. Decedent's Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	(Give life. L	lent's Usual Occupi kind of work done o DO NOT use retired tment Man	during most of work)	ing 1	6b. Kind of Bus	iness/Industry ing Mfg.
Q	should be filed nd Mental Hygi marked other ımatic event, <u>ti</u>	To Be Co	17. Father's Name (First, Middle, Last John Miller)			18. Mother's Name	e (First, Middle, Martha Ir		'
Maryland	nd 2 should be alth and Mental 27 is marked c r traumatic eve	-	19a. Informant's Name/Relationship (Victor McSherry -			ng Address (Street a				State, Zip Code) Maryland 21740
altimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev once.		20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specia	Removal from State		sition (Name of matory or other place wn Memori	′ : -	10,		own, Maryland
Balt	permit. Departr importa any inji		21. Signature of Funeral Service Lice	ankin		Name and Address 5 East Wi		Minnich H d., Hage		Home Maryland 21740
The second	Physician /Medical Examiner	Sequentially list conditions, in any leading to finine lists cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of):							Approximate Interval Between Onset and Death Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Cons	
68760,	icate be executed physician and s the burial-transit	dical Exa	resulting in death) Last	Due to (or as a cond.	nsequence of):	Dehra	il In	suffici.	once	+ Year
P.O. Box 6	The law requires that the death certificate has been signed by the attending plage 2 should be detached for use as it	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 mopths? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pro 1 Live birth 2 L 4 Pregnant at time 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	1		and. Date Mon	e of delivery th Day Year
ords, P.	w requires that is been signed by should be deta	by	Part II. Other significant conditions	contributing to death but not	t resulting in the u	nderlying cause giv	en in Part I.	23e. Did tob		bute to the cause of death? 3 ☐ Probably 4 ☐ Unknown
or Vital Records,		Completed	- Om Re	effel	R Ce	mel	<i></i>	24a. Was ar autops perforn 1 Yes 2	y prined? di	Vere autopsy findings available rlor to completion of cause of eath? ☐ Yes 2☐ No
or Vit	Physician: this certific	To Be	25. Was case referred to medical examiner?		2 ER/Outpatier		er: 4 ☐ Nursing H	ome 5 Reside	nce 6 □Othe	
Division (ding h. After fune	Certification:	27. Manne of Death 1 Natural 5 Pending 2 Accident investigation 3 Sufficiel 6 Could not be determined	28e. Place of injury -	At home, farm, sti	M 1□	yat k? Yes 2∐No	28d. Describe ho	reet and Numbe	er or Rural Route Number,
ă	To the Hospital or Attens within 24 hours after deart To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying P	hysician: To the best of my	y knowledge, deat				ause(s) and mar	
	o the Ho ithin 24 h o the Fu ompletel	Medical	(Check only 2 ☐ Medical Example) 29b. Signature and title of certifier	miner: On the basis of exa and manner stated.		29c. Licens	e number	25		(Month, Day, Year)
1	150		Jan 1	W MU	(Here CO-) (7	Printegul	045031	1	April	13th 2009
	5		30. Name and address of person who Superson	BD7QU1		Eaul	etan	& the	99781	own and
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) APR 1 4	32. R/gistrar's S	A A	and !			,	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year Physician 9:15 P M 2009 April Dale Everett Maple 11 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 10924 Knotty Pine Drive Hagerstown Washington 8. Date of Birth (Month, Day, Year) Sept . 17, 1912 9. Birthplace (State or Foreign Country)
Indiana 5. Social Security Number 7. Age (In yrs. last birthday If Under 1 Year | If Under 24 Hrs. **Funeral** Months Days Hours 1**X** M 2 □ F 372-10**-**8981 96 **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show the Michael Exeminer must be notified at Director 1 ☐ Yes 2X No Maryland Washington Hagerstown 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21740 10924 Knotty Pine Drive Funeral items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2**X** No If Yes, Give Year or Dates: 1 Never Married 2 Married "natural", or 1 ☐ Yes 2XNo þ Specify: 3X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry s 1 and 2 should be filed within 12 of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Dry Cleaning Owner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Everett O. Maple Grace Jane Tate Pages 1 and 2 should မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health a
Important: If Item 27 is
any injury or other trau 10924 Knotty Pine Drive Hagerstown, Maryland 21740 Jewel-e George - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2XXCremation 3 ☐ Remo from State 4 ☐ Denation 5 ☐ Other (Speed Smithsburg Crematory | April 24,2009 | Smithsburg, Maryland 21. Sonature of Juneral S Ostorne AdFune Fally Home, P.A. 425 S. Conococheague St. Williamsport, MD 21795 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (ar as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): physician the burial Physician/Medical attending p for use as t 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 5 Other (specify) been signed by the s should be detached f ☐Yes 2 ☐No 9 Unknown 9 Unknown Part II. Other significant condition contributing to deal aut not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 X No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy performed yes 2 UNo certificate 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only only) Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Box 68760. Ö 9 Records, Vital or Attending Physician: ot Division

Baltimore, Maryland 21215-0036

within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

To the 1 within 2 To the 1 VH-5

Hospital

State Registrar 31. Date filed (Month, Day

5 ☐ Pending investigation

6 □Could not be

27. Manner of Dath

Natural Natural

2 Accident

4 Homicide

29b. Signature and title

3 ☐ Suicide

29a, Certifier

APR 13 200

28a. Date of Injury (Month, Day, Year)

and manner stated.

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

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Funeral	5. S	ocial Security Number	6. Sex		7. Age (In yrs.	last birthday)	If Ur	nder 1 Year	If Under		. Date of B	Birth (MM	/DD/YYYY)		place (State	or Foreign
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Physician	23a	a. Part I. Enter the disease, o failure. List only one cause	r/complica e on each	itions that o line.	aused the dea	ith. Do not enter	the mo	de of dying,	such as ca	ardiac or re	espiratory a	arrest, si	nock, or nea	11	Between C	Onset and
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Box 68760, e death certificate be the attending physical for use as the buri	IF I	FEMALE: . Was decedent pregnant in	the		outcome of pr		atal da	ath 3	Ectonic	pregnanc	·v	2	3d. Date of Month		ay	Year
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Division of Vital Records, P.O. tal or Attending Physician: The law requires that the real after death. al Director: After this certificate has been signed by the fineral director, page 2 should be deach the fineral directory.	<u>a</u>										1	Yes 2	✓ No 3	Prob	ably 4	Jnknown
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Phys er this		1 ✓ Yes 2 No Manner of Death			e of Injury	28b. Time of			iry at Work	? [2	8d. Descri	be how	niury occurr	ed		
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Division spital or Attend hours after death where I prector y filled in by the 1	Suicide 6 Could not be determined (Specify) Major Prod / Highway Rt. 63/ Greencastle Pike N/O Ft) Frenc	ch Ln. , Hag	gerstown,					
hou hou		a. Certifier 1 Certifying	Physician	. To the he	est of my know	ledge death occ	urred a	t the time d	ate and old	ace, and d	ue to the c	ause(s)	and manner	r as state	ed.	
the H in 24 the F	edical		aminer: C	n the basis	of examinatio	n and/or investig	gation, i	n my opinior	n, death oc	courred at t	the time, d	ate and	place, and d	lue to th	e cause(s)	
To To COU	29	b. Signature and title of certi	a	nd manner	stated.			29c. Licens							nth, Day,Yea	r)
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Sta	to 31	. Date filed (Month, PRY		I aa r	Registrar's Sign		,									
Registr	ar	APRI	'3 20		BARRENK N	1. 4										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienery 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death April Welda Tillman Mitchell **Physician** 2009 2:20 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Annapolis LaCasa Assisted Living 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 24, Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1921 Months Days Hours Min 1 □ M 2 🔀 F 260-24-0007 87 May Georgia Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be nettined at once. Crofton Maryland Anne Arundel 1 □Yes 2XXNo Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21114 U.S.A. 1663 Wickham Way Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 25No Specify. Specify: δ White 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Verda O'Quinn Robert Reppard Tillman ൧ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Horace Mitchell/son 1663 Wickham Way Crofton, Maryland 21114 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition ₩Burial 2 ☐ Cremation 3 ☐ Removal from State Stewart Baptist Cem. 4/18/2009 Covington, Georgia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 0 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 5 disease or condition resulting in death) /Medical Examiner CLER 10 (Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, <u>۾</u> 2 No 3 Probably 4 Unknown 1 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopo, performed r 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Ft.L.t Hospital: Other: 4 Nursing Home 5 Residence 1 | Yes 2 | No 1 Inpatient 2 ER/Outpatient 3 DOA Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Matural 5 Pending investigation 1 Tyes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who comp

31. Date filed (Month, Day, Year)

Ce (

TAL DR. LIWTHICUM

leted cause of death (Item 23a) (Type,

SIL

32. Pegistrar's Signature

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) O4 Year :05 A 2001 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Name (If not institution, give street end number) Mitchellville Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthday) 5. Social Security Number 6. Sex 84 Months 1 □ M 2 □ VF 224-46-8174 Usual Residence of Decedent Yrs. 3/21/1925 Champaign, 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 X Yes 2 □ No Mitchellville Prince George's 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20721 10450 Lottsford Road 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Education Administrator 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Ursula Vetter Edward A. MacLean 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 14111 Oak Grove Road, Upper Marlboro, MD 20774 Larry Harris / friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Buriat 2 ☑ Cremation 3 ☐ Removal from State 4/10/09 Alexandria, Virginia Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 4739 Baltimore Avenue Hyattsville, MD 20781 Gasch's Funeral Home, PA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) neumoma Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last obstruction, vecuvent Due to (or as a consequence of 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 2480 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Examiner for use as the burial-transit Attending Physician: The law requires that the deeth certificate be executed cartificete has

this

After

To the Hospital or Attending within 24 hours efter deeth.
To the Funeral Director: Afte completely filled in by the fune

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Funeral

Director

7 is merked other than "natural", or Nems 23s or 28s-f show traumetic event, the Medical Examiner must be notified at

end Mentel Hygiene.

permit. Peges 1 and 2 should be Department of Health and Mental I Important: If Item 27 is marked oth any injury or other traument

Physician

/Medical

Examiner

Funeral Director

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Completed

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be filed within 72 hours after death

Baltimore, Maryland 21215-0020

Physician/Medical Be Completed by Medical Certification: To

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner?

Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

1 ☐ Yes 2 ☐ ¥6 27. Manner of Death 5 Pending investigation 1. Netural 2 Accident 6 Could not be determined 3 Suicide

28a. Dete of Injury (Month, Dey Year) 28b. Time of Injury 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, Stete) La Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

(Check only one) 29b. Signature and title of certifier

4 - Homicide

29a. Certifier

29c. License number 1042049

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Upper Maulbovo. MD

State Registrar

32. Registrar's Signature

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year 9:23 **Physician** 04-11-2009 MARJORIE R. McCLURE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Towson Baltimore GILCREST HOSPICE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10-02-1923 Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Hours Months Days 1 □ M 2 🗓 F 85 MA 579-22-6761 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City. Town or Location 10a. State 10b. County show r than "natural", or items 23a or 28a-f sho 1X Yes 2 □ No Director Maryland Baltimore Harmans 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21077 USA 3 Hanford Drive death v Completed by Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🖪 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
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Department of H
Important: If ite
any Injury or ot
once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 04-15-2009 |Suitland, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Mary Hedgman M01374 Cedar HillFH 4111 PA Ave., Suitland, MD 20746 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 4EARS **Physician** DEMENTIA disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed Exami and burial-tra Due to (or as a consequence of): ned by the attending physician detached for use as the buria Completed by Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 1 ☐ Yes 2 No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? EMPHUSEMA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown certificate has been irector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? PNEUMONIA 24a. Was an autopsy performed? Yes 2 No INVASIVE SKIN CANCER OF FACE 2 No 1 ☐ Yes 1 □ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Mother (Specify) HOSPICE 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred in by the funeral 28c. Injury at Work? 27. Manner of Death Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide 🛮 🕱 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

Division 24 hours within 24 hou

To the Fune

completely fi

Baltimore, Maryland 21215-0036

Box 68760

P.0.

Records,

of Vital

UARJORIE

State Registrar

31. Date filed /M

29b. Signature

6565 N CHARLES ST, SUITE 209 BALTIMONE, MD 21204 DANIEUE DOBERMAN, MO Registrar's Signature

rson who completed cause of death (Item 23a) (Type, Print)

D64395

29d. Date signed (Month, Day, Year)

APRIL 11,2009

Amend Item 23a per me, g890, 04723709dib lnk. Ensure All Copies Are Legible.

			Amend Item 23	State of M	88907	747'Z37	Uyan i	t of H	lealth a	and Me	ental Hyd	niene			
			1- State Amend Item 25	per me,	3890°,0	14 / 22 / 1 Cer	U9dfib tificat	e of i	Death	THO IN	-intar i ry (Reg No.	2009	13	3236
			Decedent's Name (First, Middle, Las								2. Date of Dea			3. Time	of Death
	Physici			IGAULT,	TR.						APRIL	06.	2009	3:51	nm^M
	/Medio		4a. Facility Name (If not institution, give	<u>-</u>			4h City	Town or	Location o		711 1(11)		County of Death		Pitt
1	Examir	ıer	2167 CRAIN HIG				4b. Oity,		LDOR				CHARLE		
			5. Social Security Number 6. Se			ast birthday)	If Under	1 Year	If Under		B. Date of Birt				or Foreign
	Funeral Director			2 F	64	Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Day FEB.		945	place (State intry) NOR	
			Usual Residence of Decedent								reb.	10,1	940	CARO	LINA
	yland		10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside	City Limits
	Mar Mar	tor	MD CHAR	LES		WAL	DORF							1 🗀 Ye	s XXNo
	r 28s	irec	10e. Street and Number				10f. Zip	Code				10g. Citiz	en of What Cou	intry?	
	h witi	Funeral Director	2167 CRAIN HI	GHWAY #4	413			206	01			UNI	TED ST	TATES	
	deet	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S	3. 66 13.	Vas Deced	dent of H	ispanic Orig	gin? (Spec	ofy Yes or No- lican, etc.)		4. Race - Amer Black, White	ican Indian,	
9	or Its	F	1 ☐ Never Married 2 ☐ Married	1 X X es 2 🗆	No t	0	ries, spec 1 ⊡ Yes		Specify:	i, rueito ri	ican, etc.)				
93	ral.	1 by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	6-08-	-68	105	AT TANO	зресну.				Specify: BI	LACK	
215-0036	within 72 hours after deeth with the Maryland ans. Than "natural", or Itama 23a or 28a-f ahow ta Madical Examiner must be notified at	Completed	15. Decedent's Ed (Specify only highest gra-	ucation de completed)		16a. Deced	dent's Usua kind of wo	al Occup	ation during most f)	t of workin	q	16b. Kir	nd of Business/I	ndustry	
21	athin Ber	ημ	Elementary/Secondary (0-12)	College (1-4or	5+)				ENG			D	RIVATE	,	
2	filed w Hygier ther ti		12TH	88		71/1									
2	tal H	Be	17. Father's Name (First, Middle, Last) BOSTON MANIGA	מס מדוד							(First, Middle,			n	
<u>×</u>	should be nd Mental markad o	မ			•				MAR		ROWN		IGAULT		
Maryland	2 sho		19a. Informant's Name/Relationship (7				-						Town, State, Z.		0601
	Pages 1 end 2 should be filed within 72 hours after deeth with the Marylan nent of Heath and Mental Hygiene. Int: If item 27 la marked other than "natural", or itema 23e or 28e-f ahow iry or other traumatic event, the Madical Examiner must be notified at		LAURA L. MANIG	AULT/ W.	IFE	ace of Dispo			TGHV	Da			DORF,		0601
0			20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □	Removal from State	RTV	ERDA REMAT	natory or o	ther place	e) A	APRII	. 09,		cation - City or 1 VERDAI		D
Ë			4 □ Donation 5 □ Other (Specify		ČŘ					2009					
Baltimore	permit. Page Department o Important: If any njury or 2009.		21. Signature of Funeral Service Licen	see A	uso	_ T	Name ar	nd Addres	s of Facilit	уони:	SON FU	JNER	AL SEF	RVICE	,PA
	20 ≥ a α		TERRENCE L.	JOHNSON									hite F		
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that cause one cause on each l	d the death. ine.	. Do not ent	er the mod	te of dyin	g, such as	cardiac or	respiratory ar	rest,		Approximately Approximately Interval Biometric Approximately Inter	etween
3	Physician		Immediate Cause (Final disease or condition	a. Cack	nexic	x of 1	JNK	noc	د بردر	etic	logy			E P	rest
7	/Medical Examiner		resulting in death)	Due to (or as	a consequ	ence of):						of	7	0	-
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	st ad	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	_	,		0	,		0 61	MEDIC	AL EXAM.		- 	0
	ecute end -tran	cam	that initiated events resulting in death) Last	C		Mar	1 VI		ion.	TOPPI	MED BY			2.21	4.14.
760,	ate be executed hysicien end the burial-transit	Ē		Due to (or as	a consequ	ence or).			CERTIFICA	404					
	cate ohysi the t	dicai		d					CEL					-	
x 68	Physician: The law requires that the death certifica this certificate has been signed by the attending ph ral director, page 2 should be detached for use as th	Physician/Med	IF FEMALE:	23c. If yes, outcome	of prognar	201									
Вох	atten atten for us	ian	23b. Was decedent pregnant in the past 12 months?	1☐Live birth 4☐Pregnant a	2 Fetal	death 3	Ectopic pr					2	3d. Date of deliment Month	very Day	Year
Ö	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊟ Pregnant a 9⊟ Unknown	it time or de	aun 5∟	Other (sp	жеспу) <u> </u>							
P.0	that the detack	P.	Part II. Other significant conditions of	entributing to death t	out not resu	Iting in the u	nderlying c	ause giv	en in Part I.		23e. Did to	bacco us	se contribute to	the cause of	f death?
Records,	sign d be	d by	Bilateral.	Kip f		ture					101	'es 2[No 3□Pro	bably 4	Unknown
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æ	sicien: The law certificate has b irector, page 2 s	Completed									24a. Was autop		24b. Were aut prior to c death?	ompletion of	cause of
<u>=</u>	r: Th icate r, pag										1 ☐ Yes			2 No	
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ō	Phys this raldi	5	1 XYes 2 No 27. Manner of Death	1 ☐ Inpati		ER/Outpatien 28b. Time of		Bc. Injur	4 🗆 190		e 5 Resid		Other (Spec	ufy)	
5	ding After fune	E I	1 Natural 5 ☐ Pending	(Month, Da	y Year)	Injury	м	Wor	k? Yes 2 □ I		od. Describe i	io w injury	occurred		
isi	deatl deatl ctor: the	ica	3 ☐ Suicide 6 ☐ Could not be		iury - At hor	me farm str					RI Location (S	Street and	Number or Ru	ral Route Nu	mher
Division of Vital	or A efter Dire	erti	4 Homicide determined	building, e	tc. (Specify,)	eor, ractor	y, onice			City or Tox	m, State)			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	spital ours neral filled	O I	29a Cartifior 1X Certifying Ph	ynician: To the best	of my know	viertra itanti	Sperimen	at the tin	ne data a	Sidney n	of due to the	(a)eauen	and marke as	status!	
	24 h 24 h Fur etely	Medical Certification:	(Check only 2 Medical Examone)	iner: On the basis of and manner st	of examinati	ion and/or in	vestigation	, in my o	pinion, dea	th occurre	d at the time,	date and	place, and due	to the cause	o(s)
	To the Hospital or Attending Physician: within 24 hours stefar death. To the Funeral Director: After this certifica completely filled in by the funeral director;	Me	29b. Signature and title of certifier				290	c. Licens	e number			29d. Date	signed (Month	, Day, Year)	1
	- s - ō		Sollioh Im	nani	M .	D .	7	D 3	520	15		4	. 8.00	7	
			30. Name and address of person who		death (Item	23a) (Type	0.1				-				
R	32		10 St. Patricks		SC	sites	208	, u	olo	ront	, MI	22	0603		
	Sta	ate	31. Date filed (Month, Day, Year)	1		_				4					
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene [] [] 9 Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month 04 09^{bay} **Physician** 200^year 9:05 а м Nickens Beatrice Μ. /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's 140 Onondaga Dr. Oxon Hill If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🔀 F Yrs. Director 83 12/25/1925 579-22-4453 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ?7 is marked other than "natural", or items 23a or 28a-f show treumatic event, the Modical Exeminar must be notified at 1 X Yes 2 ☐ No Director DC Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 20018 NE e filed within 72 hours after death val Hygiene. I other than "natural", or items 236 1430 Saratoga Ave. Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Completed by 3 ☐ Widowed 4 ☑ Divorced **Black** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Coltege (1-4or 5+) 9th grade Domestic Engineer Housekeeping permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth eny injury or other treumatic event ODE: 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Willie Walker Elizabeth Staten 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverly Francis/daughter 3021 M St SE Washington DC 20019 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ⊠Burial 2 ☐ Cremation 3 ☐ Removal from State APril 17, 2009 4 ☐ Donation 5 ☐ Other (Specify) Harmony Mem. PArk Landover, MD 21. Signature of Tuneral Service Licenses 22. Name and Address of Facility Marshall's Funeral Home 4217 9th St. NW Washington DC 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 8/06 Metastatic Breast Carcinoma disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or rigury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed use as the burial-transit ettending physicien and Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an 1 Tes 1 Yes 2 XNo 2XNo 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 \square Nursing Home 5 \square Residence 6 \bigcirc Other (Specify) Daughter Home Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☑ No 2 this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how intury occurred Certification: To the Hospital or Attending within 24 hours after death.

To the Funerel Director: After 1 Matural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide cal 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD11355-DC 4/9/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Capitol St. NE Washington DC 20002 Bruce Cooper MD

State Registrar

DHMH 17 Rev 1/2001

. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 20<u>09</u> **Physician** 11:30 p^M April 6, Louise Poole **Evelyn** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Calvert Prince Frederick 495 Seagull Beach Road If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Country) Virginia **Funeral** v, Year Days Hours 1 □ M 2 🔀 F June 14,1914 94 216-44-5816 Director Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hyglene. m 27 Is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 'natural", or items 23a or 28a-f show ofcal Evandar in ust be notified at 1 ☐ Yes 2 XNo Director Prince Frederick Maryland Calvert 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20678 495 Seagull Beach Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2**X** No 1 ☐Yes 2**X** If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2000 No Specify: ģ 3X Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) event, the Madical 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Theodore Watkins Lelia Wyatt 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 495 Seagull Beach Road, Prince Frederick, MD 20678 Health James Poole/Son permit. Pages 1 and Department of Heall Important: If item 2 any injury or other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 x Burial 2 ☐ Cremation 3 ☐ Removal from State Charles Memorial 04/10/2009 Leonardtown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License P.O. Box 128, Charlotte Hall, MD 20622 . MOO817 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CGA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner AONTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed Due to (or as a consequence of): Box 68760, physician the burial Physician/Medical attending 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year ō 5 Other (specify) ☐Yes 2 No signed by the a o 9 Unknown ٦. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐Yes 2 ☐ No 1∐Yes 2∭HNo Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | Yes | 2 | 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred after death.

I Director: After d in by the funera After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ca 29a, Certifier (Check only one) and manner stated.

31. Date filed (Month, Day, Year)

Joseph Barth, M.D.

29b. Signature and title of certifier

32. Registra s Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lesur

MO

29c. License number

0052242

Prince Frederick, MD 20678

29d. Date signed (Month, Day, Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 26 per phys. C890 4/30/09 dk

State of Maryland / Department of Health and Mental Hygiene 2 [] [] 9 13239 Certificate of Death 2. Date of Death 3. Time of Death 1, Decedent's Name (First, Middle, Last) April 10, 2009 3:17P Paga1 Molano Patrocinio 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Prince George's Fort Washington Ft. Washington Hospital If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month Day, Year) Days 1 □ M 2 H F 81 Philippines 577-68-0245 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 □ Yes 24 No Ft. Washington PrinceGeorge's Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number LISA 20744 901 Maher Court 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 □ No If Yes, Give Specify:Filipino 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Data Processor Hospital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Feliciana Nicolas Reyes Gegeno Deguzman Molano 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1803 Fenwood Ave. Oxon Hill, MD. 20745 Victor Pagal/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cem. 4/21/2009 Cheltenham, MD. 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature uneral Service Licensee Mas 6160 Oxon Hill Rd. Oxon Hill, Md. 20745 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one carse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastatic Hepatocelluar Carcinoma disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, it is cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 XNo 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 □Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2XNo 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 🗷 Natural Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide

Examiner Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Funeral

Director

show

ral", or items 23a or 28a-f shov

permit. Pages 1 and 2 should be filed within 72 hours after death \ Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23 any injury or other traumatic event, It & Medical Examiner must any injury or other traumatic event, It & Medical Examiner must ponce.

Physician

/Medical

attending physician and for use as the burial-tran

his certificate has b I director, page 2 st

After this

Baltimore, Maryland 21215-0036

Directo

Funeral

Completed by

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Physician/Medical

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Completed

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Certification: To

Medical

29a. Certifier

IF FEMALE:

Hospital or Attending Physician: The law requires that the death certificate be executed

ours after death.
leral Director: /
filled in by the f 24 hours a within 2.

10

29c. License number

Kertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

Richard Palmer, M.D. 1328Southern Ave. S.E. Suite 310Washington, D.C. 20032

State Registrar State of Maryland / Department of Health and Mental Hygiene

10010

Physic /Med Exam

Funera Directo

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23a or 28a-f show any Injury or other traumatte event, It e Medical Examination must be notified at any once.

Baltimore, Maryland 21215-0036

Physician /Medica Examine

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Regis

	1	For State Registrar Certificate of Death Reg. No.
ian	_	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 3. Time of Death
ical		Mary Louise Puckett 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
iner		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Washington Adventist Takoma Park Prince Georges
1		5 Social Security Number 6 Sey 7 App / In urs last birth/day) If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9 Birthplace / State or Foreign
	-	257-66-3969 1 M 2 XF 71 Yrs. Months Days Hours Min. 3/19/1938 Country) Usual Residence of Decedent
	-	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
ţ	3	MD Calvert Prince Fredrick
Funeral Director		10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
ra d	3	366 Medallion Dr 20678 United States 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian.
i i	3	Armed Forces? If Yes, specify Cuban, Mexican, Puerto Ricán, etc.) Black, White, etc.
2		3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: 1 ☐ Yes 2 ☒ No Specify: Specify: Specify: Black
Completed		15. Decedent's Education (Specify only highest grade completed) (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)
8		Elementary/Secondary (0-12) College (1-4or 5+) 2yrs Homemaker Private
Re	2	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
100		Jessie Strickland Speaker Milsap
		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
	-	Dakota y. Shelton Daughter 366 Medallion Dr Prince Fredrick MD 20678 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State
		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place)
	ŀ	21. Signature of Funeral Service Licensee 22. Name and Address of Facility
	1	W.Wesley Chavis III Funeral Service P.A. 10684 Southern MD BLVD Dunkirk MD 20754 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate
ı		snock, or heart failure. List only one cause on each line.
		disease or condition resulting in death) a. WIND TIPLE GRED BUNNSULLING ALLINGS a. WIND TIPLE GRED BUNNSULLINGS A. WIND TIPLE
1		Due to (or as a consequence of): OFF DIO GE MC > NO Cic
ā		Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):
Fxaminer		Cause (Disease or influery that initiated events resulting in death) Last c. Due to (or as a consequence of):
<u></u>		bue to (or as a consequence of).
Medical		
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1
Physician		in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Month Day Year
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
Completed by		CORDMRY ARTERY DISERSE 1 Yes 21/2No 3 Probably 4 Unknown
telu		TEUTE RG MAL FALLURE 24a. Was an autopsy prior to completion of cause of
S		RESPIRATORY FAILURE performed? death? 1 yes 2 1 yes 2 1 yes 2 1 yes 2 1 yes 2 1 yes 2 No
å	ì	25. Was case referred to medical examiner? 1
T	-	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred
atio		2 Accident investigation M 1 Yes 2 No
rtific		3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
S		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
Medical Certification: To		(Chek only only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
2		29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
		1 1000 04/04/2009
		30. Name and oddress of person who completed cause of death (Item 23a) (Type, Print) OR. P.OTR M. WYRWINSKI 7600 CARROLLAVE TAKOMA PK MO 20 912
tate		31. Date filed (Month, Day, Year) 32. Registrar's Signature
trar		APR 13 2009 General B. Sarker

DHMH 17 Rev 1/2001

		1 - For Amend Item 25 State of Maryland / Den	artment of Health and Nortificate of Death	Mental Hygie Reg.	
Physi	ician	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year
	dical	Henrietta M. Pickett	T	1	08 2009 1332 ^M
Exam	niner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
Funera	ol.	Holy Cross Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Silver Spring If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Montgomery 9. Birthplace (State or Foreign
Directo		418-28-7715 1 1 M 2 M F 90 Yrs.	Months Days Hours Min.	(Month, Day, Ye 07/28/19	
P.		Usual Residence of Decedent			
aryla shov		10a. State 10b. County 10c. City, Town or L			10d. Inside City Limits 1. Yes 2. No
the M	Director	MD Prince George's Adelphi	10f. Zip Code	100	. Citizen of What Country?
with sa or	ءَ ا	3210 Powder Mill Rd.	20783		JSA
death ms 23	Filheral	11. Marital Status 12. Was Decedent Ever in U.S. 13	. Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto		14. Race - American Indian,
ire, Maryiarra ZIZIS-DUSO stand 2 should be filed within 72 hours after death with the Maryland of Heath and Mental Hygiene. The marked other than "hatural", or items 23a or 28a-f show other traumatic event, the Medical Examinations to notified at	1 2	3 ☑ Widowed 4 □ Divorced If Yes, Give Year or Dates:	if Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2 ☑ No Specify:	Rican, etc.)	Black, White, etc. Specify: Black
72 hou	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation		b. Kind of Business/Industry
thin 7	1 2	Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of work DO NOT use retired)	king	
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be fill ped out	ď	17. Father's Name (First, Middle, Last)		e (First, Middle, Mai	den Surname)
hould hould mark	Ę		LILIE I	P. Miller	Situar Town State Zin Cade)
17 is tra			Oglethorpe St. NE		
Dalliniore, IVI permit. Pages 1 and 2 Department of Health. Important: If item 27 i any injury or other tra		20a. Method of Disposition 20b. Place of Disposition			c. Location - City or Town, State
Datumit. Pages Department of mportant: If it in my injury or or or or or or or or or or or or or		145 Burial 2 Li Cremation 3 Li Hernoval from State	Mem. Gardens 4/15	/2009 Hu	intsville, AL
mit.	- SOCE		22. Name and Address of Facility Ma		
0 89E	a	I p marshall 14	217 9th St,NW Wash	nington DC	20011
		23a. Paff1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	r respiratory arrest	t, Approximate Interval Between Onset and Death
√ Physicia /Medica	_	Immediate Cause (Final disease or condition resulting in death) a. Hypotension and	Hypoxia /	4	
Examine	_	Due to (or as a consequence of):	\wedge /	11/	TAMMER
	<u>ة</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Obsease or injury)		TO BY MEDICAL	TEN
ecuted and I-transit	Fyaminer	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Pneumonia Due to (or as a consequence of):	- daron	DPROVED BY MEDICA	
icate be executed physician and the burial-transit	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	d. Aspiration	CERI		
ertifica ling place as t	Med	IF FEMALE:			
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 4 ☐ Pregnant at time of death 5 9 ☐ Unknown	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year
s that med t			underlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death?
v requires been sign	Completed by	Urinary tract infection		1 ☐ Yes	2 ☐ No 3 ☐ Probably 4 🔀 Unknown
law re as be 2 sho	1 2	Acute renal failure		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
The The page	٥	Hypokalemia		performe	d? death?
VILAI Iclan: Tertifica ector, p	8	25. Was case referred to medical examiner?		th (Check only one)	
Phys Phys r this ral dir	ļ.	1 XYes 2 Hospital: 1 Inpatient 2 ER/Outpati			ce 6 ☐ Other (Specify)
VISION OF VITAL MEN Attending Physician: The law er death, rector: After this certificate has by the funeral director, page 2.8		27. Manner of Death 1		28d. Describe how	injury occurred
Atten	1	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s		28f. Location (Stree	et and Number or Rural Route Number,
al or safter	Certification. T	4 ☐ Homicide determined building, etc. (Specify)	,	City or Town, S	State)
To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Pedical (
To the within 2 To the comple	M	29b. Signature and title of certifier	29c. License number	29d	I. Date signed (Month, Day, Year)
		MITTHE MIT) · D0064100		4/8/09
10		30. Name and address of person who completed cause of death (Item 23a) (Type BHIKKAJI 1500 Forest Glen Rd. Sil	,	910-1484	
	State	31. Date filed (Many Bay, Yay) 2009	a. W. J		
Regi		10 1 11 11 11 11 11 11 11 11 11 11 11 11	West -		

State of Maryland / Department of Health and Mental Hygiene ? 1 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2009 **Physician** 2:20 P. M April 8, Lillian G. Groom /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Calvert 11450 Asbury Circle, Apt. Solomons If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, Date of Birth (Month, Day) 5. Social Security Number **Funeral** Days Hours Min 06-07-1920 Maryland 220-16-9079 Director 88 Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10b County 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or or other traumaite event, the Medical Examiner must be notified at any Injury or other traumaite event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Solomons Director MD Calvert 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number United States 11450 Asbury Circle, Apt. 414 20688 Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 ☐ Yes 2 X No f Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2 No 3altimore, Maryland 21215-0036 Specify Specify: White þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "' Elementary/Secondary (0-12) College (1-4or 5+) Medical Record Technician U. S. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Audrey Thomas Cleavland Benjamin Grover 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Horace Curry Groom, Jr. (Husband) 11450 Asbury Circle, Apt. 414, Solomons, MD 20688 Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Paul UMC Cemetery 4/14/2009 Lusby, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. P. O. Box 600, Lusby, Maryland 20657 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) myelogenous **Physician** Two months /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 3 Ectopic pregnancy in the past 12 months?
1☐ Yes 2☑ No
9☐ Unknown Month 4□Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed page 2 should be det þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes 2♥ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director. Be Other: 4 Nursing Home Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident after death Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after dea To the Funeral Directo completely filled in by th 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 💢 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 1 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

31. Date filed (Month, Day, Year) APR 10 2000 >

Charles W. Bennett, MD 11845 H. G. Trueman Road, Lusby, Maryland 20657 32. Registrans Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sennett M. D.

April 9, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month 4:15 A. M 9, 2009 Joseph Rocco April 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Solomons Nursing Center Calvert Solomons If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number Months Days 1**X**) M 2□ F Yrs. 91 04-20-1917 PA 579-10-4513 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐Yes 2XNo Calvert Lusby 10f. Zip Code 10g, Citizen of What Country 10e. Street and Number 20657 United States 50 Appeal Lane, Apt. #220 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 TYYes 2 No If Yes, Give Year or Dates: WW II 1 Never Married 2 Married 1 □ Yes 2 🛣 No Specify: Specify: White 3 Widowed 4 Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Barber Barber 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Frances Blasco Philip J. Rocco 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances Rocco (Wife) 50 Appeal Lane, Apt. #220, Lusby, Maryland 20657 Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State MD Veterans Cemetery 4/15/2009 Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Rausch Funeral Home, P.A. P. O. Box 600, Lusby, Maryland 20657 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) RENAL FAILURE for years Due to (or as a consequence of): DW 35 yrs Sequentially list conditions, if any, leading to immediate cause. Fine Uncertains Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 TUnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HTW, CAD 2 No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 **3 M**o 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 University Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation

Physician /Medical **Examiner**

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Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

r than "natural", or Items 23a or the Medical Examiner must be

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural" or Iter any injury or other traumatic event, the Medical Examiner

Baltimore, Maryland 21215-0036

MD

Director

Funeral

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Completed

Be

death with the Maryland

Examine Physician/Medical þ Completed Be

Medical Certification; To

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

attending p after death | Director: / d in by the f

the Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

den 10+1

State

To the Hospital o within 24 hours aft To the Funeral DI completely filled in

29b. Signature and title of certifier

6 ☐ Could not be

determined

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1 ☐ Yes 2 ☐ No

RD

29d. Date signed (Month, Day, Year) 9109

LUSBY MD 2065

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MATHEW MD. 11910 H. G. TRUEMAN SCARIA

32. Registrar Signature 31. Date filed (Month, Day, Year)

2009 Cleneur

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

09-03128 Banald Law Basah		Please Type o							ole.			
Ronald Lee Rensh		State State	of Maryland		ent of Hea ete of Dea	Ith and Mental	Hygie			200	9 132	L
Physician		gistrar Decedent's Name (First, Middle,Las	t)	Ochlinca	ite or bea		2. Da	Reg. ite of Death	No.	200	3. Time of Death	-
Medical Examine	_	Ronald.	Lee	Rei	15ha	W	Mc Ap	onth D ril 19, 200	ay 19	Year	0637 hrs	
{	48	Facility Name (if not institution, give 600 blk of Rt. 40 East	e street and number	•)	4b. City, Elkto	Town, or Location of Do	eath		4c. Coi Ceci	unty of Death		
Funeral	5.	Social Security Number 6. Se	x 7. A	ge (In yrs. last birth		der 1 Year If Under 24	4Hrs. 8. [Date of Birth(1		place (State or	\dashv
Director	2	12-50-7080	M 2 F	51	Yrs. Mon	ths Days Hours	Min.	10-19	-195	Foreigr Cou	ntry) MD	
*	_	sual Residence of Decedent	`					W II			10d. Inside City Limi	
ow any		a. State 10b. County	1	10c. City, Town of							1 Yes 2	
the Maryland a or 28a-f sh	<u>5</u> 10	MD CCCI	L	ELKY		ip Code		10g.	Citizen	of What Coun	try?	\dashv
72 hours after death with the Maryland n "matural", or items 33a or 28a-f she al Examiner must be notified at once		104 E. Main	Stree	t		21921				USA		
er death with	P 11	. Marital Status	12. Was Deceden		13. Was Deced	dent of Hispanic Origin?				Race - Americ White, etc.	an Indian, Black,	
er deat		Never Married 2 Married Widowed 4 Divorced	1 Yes 2	No No	1 Yes	2 No specify:		, , , ,	Sne	ecify: Wh	ite	
urs after tural" amine	3 −	5. Decedent's Education (Specify or	Lor Dates:		Decedent's Usua	al Occupation (Give kind		one 1		of Business/Ir	ndustry	
6 172 ho an "na cal Ex		Elementary/Secondary (0-12)	College (1-4 or	- 5+) C	luring most of w	orking life. DO NOT use	e retired)			F-1	` -	
withir withir her the	nataidillo	12 '. Father's Name (First, Middle, Last)				Contract 18, Mother's N	TOV	Middle Mai	den Sun		ring	_
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	. 1	lerbert Dav	. 1	nshaw	,	70	da	A	1,f	C		
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filted within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 7: is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.		a. Informant's Name/Relationship (T	ype, Print)			ss (Street and Number	r or Rural I	Route Number	r, City o	r Town, State,	Zip Code)	
ME 3 should be s	20	Leda Uwer Da. Method of Disposition	15/mot		5 W. I	MILIAMS ame of cemetery,	Kd.	e [-	K+	ation - City or	10 21721 Town State	
iore ges 1 a t of Ha : If it	1	Burial 2 Cremation 3	Removal from S	State cremato	ory or other plac	e)		Ì	. ,		N /	
Iltim nit. Pa artmen ortani	2	Donation 5 Other Specify Signeture of Funeral Semice Light		United	22. Name ar	ry Services (ddress of Facility					DE	
Dep Dem		Edward Ille	low		Stran	churchma	n5	neval Road	Nei	ome wark	DE 1970	2
Physician /Medical	23	Ba. Part I. Enter the disease or comp failure. List only one gause on ea		d the death. Do no	t enter the mode	e of dying, such as card	lac or resp	iratory arrest	, shock,	or heart /	Approximate Inter- Between Onset ar	
xaminer			Morphine Due to (or as a con-		ation						Death	_
	s	equentially list conditions, b.	200 10 (0) 40 4 001									
	if e	any, leading to immediate	Due to (or as a con	sequence of):								
st. sd	e (I	Disease or injury that initiated vents resulting in death) Last	Due to (or as a con	sequence of):								
execu in and il - tra	=	X UNPENDED	AMENDED 23	a,27,28a	-f,perM	E, g891 5/1	14/09	TT				
	Medi	FEMALE:		ome of pregnancy					23d. D	ate of delivery		
687 certific	23	b. Was decedent pregnant in the past 12 months?	1 Live birth	at time of death	Fetal deaf		regnancy		Мо	nth D	ay Year	
Box 68760, e death certificate be the attending physic red for use as the bur	Pnysician/med	Yes 2 No 9 Unknown		at time of death 5	Other (St	pecify)						
cords, P.O. B law requires that the d has been signed by the 2 should be detached	P.	art II. Other significant conditions	contributing to dea	ath but not resulting	in the underlyi	ng cause given in Part I	i.				the cause of death?	
S, P quires t					······		- 1	1 Yes 24a. Was an		20.78	ably 4 Unknow topsy findings availa	
ord law rec has bee 2 shou	Completed			<u> </u>			- 1	autopsy perform			ompletion of cause of	
tal Rec		5. Was case referred to medical				26.Place of Death (Cr		Yes 2		1 🗸 Ye	s 2 No	_
Vital ysician:	ň		Hospital: 1 Inpat	tient 2 ER/Ou	utpatient 3	Othor	Jursing Ho		esidence	e 6 🗸 Other	: Scene	
of Viing Physical After this Funeral dir	2	7. Manner of Death	28a. Date of In (Month, Day	njury 28b. T	Time of Injury	28c. Injury at Work?		Describe ho	w injury	occurred		
Sion Attendi death. ctor:	Satio	Pending			0600 h							
Division of Vital Records, P.O. ontail or Attending Physician: The law requires that the cours after death. Filed in by the funeral director, page 2 should be detach.	Certification:	determine	be	Injury - At home, fa wooded a		ory, office building, etc.	28f.	or Town, Sta	eet and te) MR	Number or Ru)0 Blk.	ral Route Number, C Rt 40 Ea	st
h ba bi		la Certifier		my knowledge, dea	ath occurred at t	he time, date and place						_
To the Host within 24 hc To the Fun completely		2 Medical Examine	r:On the basis of ex and manner state	amination and/or ind.	nvestigation, in	my opinion, death occur	rred at the	time, date ar	d place,	and due to th	e cause(s)	
	2	b. Signature and title of certifier		`	2	29c. License number					nth, Day, Year)	
		More and address of	fompleted as	Ideath (Now 225)		O.C.M.E.			APIII Z	0, 2009		_
	3). Name and address of person who Russell Alexander MD	completed cause of Assistant Med		111 Penr	Street, Baltimore	e, MD 21	1201				
Star		1. Date filed (Month, Day, Year)	32. Regist	rar's Signature	parkel							
Registra	_	APR 22 200	13 Kanin	7- 7-								
DHMH 17 Rev 1/200	1			OR	IGINAL				00111			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2009 ear **Physician** April 6:45 A. M Carrie Lee Richardson /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Cheverly Prince George's Prince George's Hospital Center Birthplace (State or Foreign Country)
 Carolina Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 6. Sex **Funeral** Days Hours Months 88 09/09/1920 1 M 2 F Director 577-30-1854 Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a, State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 □ No Directo Washington D.C. 10g. Citizen of What Country? 10e. Street and Number 20019 U.S.A. 707 49th Pl., N.E. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc.
African-1 Tes 2 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐Yes 2 No ģ Specify: American 3 Widowed 4 □ Divorced Year or Dates: Completed of Health and Mental Hygiene. item 27 Is marked other than "natur other traumatic event, In Wedon 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hospital Nursing Assistant 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sarah Garrett Robert Gilchrist မှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2410 Fairhill Dr., Suitland, Maryland 20746 Olivia Richardson/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or ot
once. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Lincoln Mem. Cem. 04/13/09 Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
H.S. Washington & Sons Co., Inc.
4925 Burroughs Ave., N.E., Washington, D.C. 20019 Signature of Funeral Service Licensee Jan. radi 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Fatal Cardiac Arrhythmia disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Cardiomyopathy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed Sepsis Syndrome and Due to (or as a consequence of) attending physician for use as the burial Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 ∐Yes 2 ⊠No 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Chronic Renal Failure 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Advance Age autopsy performed 1 ☐ Yes 2 ☐ No 1 ∐Yes 2 DMNo Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐ Yes 2**½** No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this safter death.

I Director: After this d in by the funeral d 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 ☑ Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. withir 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0052865 April 8,2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) K. Michael Figuero, M.D. 3001 Hospital Drive, Cheverly, Maryland 20785 State Registrar

			1 - For Stata Ragistrar	State of Maryla		artment of l			iene g. No 2009	13246
	Physici /Medio		1. Decedent's Name (First, Middle, Last) Barry Sha	be				2. Date of Death Month	3 2001	3. Time of Death
<i>;</i> 	Examir	ner	4a. Facility Name (If not institution, give s Anne Arundel Medic 5. Social Security Number 6. Sex	cal Center	s. last birthday)		polis If Under 24 Hrs.	8. Date of Birth	Anne Aru	ndel
l.	Funeral Director		540-42-4326 Usual Residence of Decedent]M 2□F 66	Yrs.	Months Days	Hours Min.	(Month, Day, 05-08-19	942 Oreg	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, it a M-sicel Examine the inclined and once.	Director	MD Anne Art		City, Town or Lo	Churcht	on	10	g. Citizen of What Cour	10d. Inside City Limits 1 ☐ Yes 2 🎇 No
	death with ms 23e or	Funeral Dir	5601 Carvel Stree	12. Was Decedent Ever in	U.S. 13.1	2073	Hispanic Origin? (Sp	ecify Yes or No-	USA 14. Race - Americ	can Indian,
9000	hours after ural', or Ite	þ	1 ☐ Never Married 2 ሺ Married 3 ☐ Widowed 4 ☐ Divorced	Amed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: 1962	2-66	1 ☐ Yes 2 🎇 No			Black, White, Specify: Whi	te
Maryland 21215-0036	d within 72 t jiene. r than "nat	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give life. I	dent's Usual Occu kind of work done DO NOT use retire rical eng	during most of work ad)	ing	6b. Kind of Business/In defense cor	
yland ;	ould be filed Mental Hyg arked othe atic event,	To Be C	17. Father's Name (First, Middle, Last) John Vernon S	Shobe			18. Mother's Name	e (First, Middle, M		
	is 1 and 2 sho of Health and item 27 is m other traum		Marilee B. Shobe, 20a. Method of Disposition	spouse	5601	Carvel S	Street, Ch	urchton,		
altimore,	iit. Pages artment of h ortent: If ite injury or of		1 Burial 2 Cremation 3 R. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License	Me	tropoli	sition (Name of natory or other pla	atory 04-	04-2009	Oc. Location - City or To $Alexandria$ eral Home,	. VA
Ba	permi Depa Impo any ir		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the dea	- 8	325 Mt.	Harmony L	ane, Owi	ngs, MD 207	36 Approximate
A.	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conse	-	CONCE			-	Interval Between Onset and Death
8760,	death certificate be executed be attending physician and dofor use as the burial transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury that initiated events resulting in death) Last	Due to (or as a conse						
P.O. Box 68	death certif e attending id for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregr 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3 🗌	Ectopic pregnanc	у		23d. Date of delive Month	ory Day Year
	The law requires that the tee has been signed by thoage 2 should be detache	by	Part II. Dther significant conditions con	tributing to death but not re	sulting in the ur	nderlying cause giv	ven in Part I.		acco use contribute to the	
al Reco	: The law racate has be page 2 sh.	Completed						24a. Was an autopsy performe	prior to cor death?	psy findings available impletion of cause of
Division of Vital Records,	Attending Physician: The in death. ecfor: After this certificate he by the funeral director, page	atlon: To Be	25. Was case referred to medical examiner? 1 Yes 2 No Ho 27. Manner of Death Natural 5 Pending 2 Accident investigation	ospital: 1 Inpatient 2 [28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Injui Wor			ce 6 Other (Specify	e)
Divis	or At fter c Direc in by	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At I building, etc. (Spec	home, farm, stre	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or Rura State)	l Route Number,
	To the Hospital or At within 24 hours after or To the Funerel Direct completely filled in by	Medical	one) 2 Madical Examin	ician: To the best of my kr ar: On the basis of examin and manner stated.	nowledge, death nation and/or inv	estigation, in my c	ppinion, death occurr	ed at the time, dat	e and place, and due to	the cause(s)
	`	-	29b. Signature and after of certifier	Y D		29c. Licens			d. Date signed (Month, 14-03-23	
JR.	1001	to i	30. Name and address of person who con 31. Date filed (Month, Day, Year)	The state of death (Ite 2008) But a sign of death (Ite 2008) B	RUS	v. te 701	Drngi	lis MO	21401	
*	Sta Registr		APR 07		N B.	barker	,			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death APRIL Vear **Physician** 6:04 AM SMITH ELEANOR 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** University of Maryland Medical Center BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 455 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 M 2 F **Funeral** Hours 212-66-23 Months Days Director Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla. Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the "Addant Expriser, until be notified an once. Caroline 1 Yes 2 No **Funeral Director** MD Denton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA avoli 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11, Marital Status Black, White, etc. 1 □Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2 No Specify þ 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4dult rovider 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Holland rnestine Boulden roy ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Rel sionship (Type. Print) 406 Moton St. Apt. 208 Easton, Maryland 21601 Shelly 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Stephens Cometery! 4 ☐ Donation 5 ☐ Other (Specify) Easton, Maryland 22. Name and Address of acility
HENRY FUNERAL 21. Signature of Funeral Service Licensee Home 510 Washington St. Cambridge, MD. 21613 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Aspiration **Physician** 24 hours /Medical Due to or as a consequence of): Examiner Buckerial Peritonitis Stontaneous Week Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed circhosis 7 months burial-tran and Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical cholangitis riman erosing Yeurs IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 Pregnant at time of death 9 Unknown 5 ☐ Other (specify) the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ð liver disease 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? certificate 2 1No 1 Yes Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 24 hours after death. Funeral Director: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier ical completely and manner stated. within 2 NFI 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar Baltimore

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JANELL ALDEN

32. Registrar's Signature

5.

31. Date filed (Month, Day, Year)

Greene

1174725071

21201

6,2009

Medical ICU)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

		1	For State	State of Ma	ryiand	•	rtificate of			Reg. No.	nna	132	1.8	
			Registrar Decedent's Name (First, Middle, La	st)					2. Date of Dea	th	Year	3. Time of 1	Death	
Physician /Medical			Mary S. Strong						March 3		2009	2:00A	М	
Examiner			4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death								County of Death			
			Riderwood SNF 5. Social Security Number 6. S	Silver Spring s. last birthday) If Under 1 Year If Under 24 Hrs.			8. Date of Birtl		Montgomery 9. Birthplace (State or Foreig					
	ineral rector	4	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 Nonths Days Hours Min. Ohio 91 Yrs. Hours Min. 12/29/1917 93. Birthplace (State or Foreign Months) Days Hours Min. 12/29/1917 94. Birthplace (State or Foreign Months) Days Hours Min. 12/29/1917 95. Birthplace (State or Foreign Months) Days Hours Min. 12/29/1917											
fand	M ti		10a. State 10b. County 10c. City, Town or Location 10d								10d. Inside Cit			
Магу	Fages 1 nent of H ant: If ite ury or ott	ctor	Maryland Montgome	ry	Silv	er Sp	ring					1 ☐ Yes	2 💢 No	
h with the		Funeral Directo	10e. Street and Number 3128 Gracefield I	20904			10g. Citizen of What Country? USA							
U36 irs after deat		by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:	Ever in U.S Io	- 1	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 No	dispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- Bican, etc.)		4. Race - Ameri Black, White, Specify: Whi	etc.		
5-0		Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)		16a. Dece	edent's Usual Occup kind of work done	oation during most of work d)	ing	16b. Kin	d of Business/Ir	idustry		
vithin :		id m	Elementary/Secondary (0-12)	5+ College (1-4or 5	+}		DO NOT use retire			Puhli	shing/H	ligher	tion Educa	
filed v Hygie		ပ္သ	17. Father's Name (First, Middle, Last			201001	and Edd	18. Mother's Nam						
ld be ental		To Be	Gilbert P. Symo		Lydia R				oth					
ary shou and N		-	19a. Informant's Name/Relationship			•			r, City or Town, State, Zip Code) 07 Wash. D.C. 20003					
and 2			Judith N. Bonior/	Daughter	nob D			-	.E. #II(3	
^ ~ ~ ~			1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Kalas Crematory 4/1/2009 Edgewater, Maryland											
Balt permit. Depart			21. Signatur Funeral Service Ligensee 22. Name and Address of Facility GEORGE P. KALAS FUNERAL HOME 2973 Solomons Island Rd. Edgewater, MD. 21037											
	hysician he executed by hysician and hysician and street prival-transit as the britial-transit		23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one gause on each line. Approximate Interval Between Onset and Death								e ween			
Phy			Immediate Cause (Final disease or condition Colon Cancer											
			resulting in death) Due to (or as a consequence of):											
750		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	as a consequence of):									
ecuted		Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C Due to (or as			a acceptance of								
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P,O, Box	To the Hospital or Aftending Prystician: The law requires that the death cert within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Physician/M	FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)							2	23d. Date of deli Month		Ye ar	
that 1		y Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death?				
ouires		ed b	Bowel Obstruction 1 Yes							Yes 2[2 1 No 3 Probably 4 Unknown			
e law re		Completed by	Anemia		24a. Was auto			s an 24b. Were autopsy findings available prior to completion of cause of death?						
<u>а</u> Т ды			Hypertension							1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No				
Vit slclar		Be c	25. Was case referred to medical examiner? 1 Yes 2 Ves Yes 2 Ves Yes Ye											
of 19 Phy		n: To	27. Manger of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Work? 28d. Describe how injury occurred Work?											
SiOr rendin		catic	1 Matural 5 Pending (Month, Day, Year) Injury Work? 2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be Peo Place of Injury. At home form street factory office.						00/ 1	294 Location (Ctreat and Number or Pural Pouts Number				
Division of Vital Records, at or Attending Physician: The law requires the after cleath.		Certification: To	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined Could not be de						28f. Location (Street and Number or Rural Route Number, City or Town, State)					
Hospita		edical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
To the		Me	29b. Signature and title of certifier	0 0	_		29c. Licer	se number			te signed (Monti			
			Nachulle	Wegio	w	Mp		144156	23	31	31/20	09		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rachelle Alexion, M.D. 3110 Gracefield Road, Silver Spring, MI									D. 20	0904				
	State Registrar 31. Date filed (Month, Day, Year) APR 0 1 2009 32. Registrar's Signature APR 0 1 2009													

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death ^{Day} 2009 **Physician** Patricia Diane Sprow April 3:19 P. 6, /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince George's Hospital Center Cheverly Prince George's If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) Date of Birth (Month, Day. Funeral Months Days Hours Min. 1 □ M 2 □ F 58 579-68-4836 08/20/1950 Director Wash.,D.C Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County ral", or items 23a or 28a-f show Examiner is ust be notified at Md. P.G. Seat Pleasant ¥∑Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 307 70th Street 20743 U.S.A. by Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify Black Specify: 3 Widowed 4 Divorced marked other than "natural", Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Securities Exchange Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Commission 12th Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Donald Beverly Margaret Lewis 7 is marked traumatic e 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau Herbert O. Sprow, Jr. / Husband 307 70th St., Seat Pleasant, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Harmony Mem. Park 04/14/09 4 ☐ Donation 5 ☐ Other (Specify) Landover, Maryland 22. Name and Address of Facility
H.S. Washington & Sons Co., Inc.
4925 Burroughs Ave., N.E., Washington, D.C. 20019 21. Signature of Funeral Service Licensee ani 23a. Part 1. Enter the disedse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Fatal CArdiac Arrhythmia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Hydrocephalus 24b. Were autopsy findings available prior to completion of cause of death? Encephalopathy 24a. Was an autopsy performed? 1 ☐ Yes 2 █ No Diabetes Mellitus 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the hurial transfer. Division of Vital Records, P.O. Box 68760,

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

State

Registrar

31. Date filed (Month, Day, Year)

29a. Certifier

(Check only one)

29b. Signature and title of certifie

Rexford Babilah, M.D. 7500 Hanover Parkway, Suite 101A, Greenbelt, Md. 20770 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

🗗 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number D66658

29d. Date signed (Month, Day, Year)

April 8,2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No./ 3 Time of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** Margaret Ann Tyler 12:10 2009 April /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Talbot The Pines Easton Genesis HealthCare - Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Days Hours 1 □ M 2 🔀 F 66 Dec. 6, 1942 Maryland Director 218-40-7479 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a. State 10b County Show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Expression in that he notified at 1 √Yes 2 No Cambridge Director Dorchester 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21613 USA 317 West End Avenue Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Baltimore, Maryland 21215-0036 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No Specify. white Yes. Give 2 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) transportation coordinator government 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Mills Oliver Preston Tyler ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret 19a. Informant's Name/Relationship (Type. Print) 8858 Roundhouse Circle, Easton, MD Alisha Saulsbury daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/13/09 Oxford Cemetery Oxford, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. ut Ilmo 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Drie to (or as a conse grence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the t attending I IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐Yes 2 ☐ No After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ≥ 4 nknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 | No 1 ☐ Yes 2 ☑ 100 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Horsing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? Injury 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 124 hours after death.

le Funeral Director: A pletely filled in by the fi 2 Accident 6 □ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 24 hou

To the Fune

completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar 30. Name and address of persor

DUTCHMANS

who completed cause of death (Item 23a) (Type, Print)

GO D

Registrar's Signature

CRNP

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month James Gardner Turley, Jr. 9:30 2009 Apri1 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Prince George's Saint Thomas More Nursing Home Hyattsville If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Months 1 X M 2 □ F 91 578-16-8804 March 11, 1918 Washington, DC Usual Residence of Decedent 10b. County 10d. Inside City Limits 10c. City, Town or Location 10a. State 1-Yes 2 No Maryland Prince George's Hyattsville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20782 United States 4922 LaSalle Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☑ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐Yes 2 😿 No Specify. Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private 12 years Maintenance Mechanic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ethel (Unknown) James Gardner Turley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5205 - 12th Street, NE Washington, DC 20011 Gail T. McCathen - Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (*Specify*) Quantico Nat'l Cemetery April 16, 2009 Triangle, VA 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Signature of Fuz rai Service 4001 Benning Road, NE Washington, DC 20019 23a. Partit. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or seart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 0 no 20 disease or condition resulting in death) Due to (or as a consequence of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 No Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

ed other than "natural", or items 23a or 28a-f show event, It elfolical Examiner must be notified at

Ith and Mental Hygiene. 27 is marked other than " r traumatic event, It of Ita

Health em 27 i

of to

item 2

= 5 Department of Important: If any injury or once.

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

/Medical

Director

Funeral

Completed by

Be

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Examiner

Physician/Medical

Completed by

The law requires that the death certificate be execute the burial-tran physician use as t signed by the a Physician:

Box 68760,

P.0.

Division of Vital Records,

or Attending

page 2 certificate After th funeral

State

Medical Certification: To Be within 24 hours a

To the Funeral I

completely filled

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? Tyes 2 No. 9 Unknown

5 Pending investigation

6 ☐ Could not be

determined

25. Was case referred to medical

29b. Signature and title of certifier

1 Yes 2 No

examiner?

27. Manner of Death

1. Natural

3 ☐ Suicide

29a, Certifier (Check only one)

2 Accident

4 Homicide

26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28a. Date of Injury (Month, Day, Year) 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 □Yes 2 □No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 ☐ Yes

2 No

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

autopsy performe

28d. Describe how injury occurred

1 □ Yes

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9 31. Date filed (Month,

Registrar

within 2 To the I

OCME

PD 5

30. Name and address of person who completed cause of death (Item 23a)

2000

Assistant Medical Examiner

32. Registrar's Signature

29b. Signature and title of certifie

Melissa Brassell, MD

31. Date filed (Month

ORIGINAL

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

April 17, 2009

State

Registra

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician John Arthur White April 5, 2009 5:20 A.M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Asbury-Solomons Health Care Center Solomons Calvert If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 11/18/1919 **Funeral** 1 XM 2 ☐ F 577-26-4690 89 Washington, DC Director Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 1 ☐ Yes 2 No MD Calvert Solomons 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 11509 Emmanuel Way #536 20688 United States Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 72 hours after 1X Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 □ Yes 2**X** No þ Specify White 3 XWidowed 4 ☐ Divorced WW II Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien. Important: If Item 27 is marked other the any Injury or other tremman. 12 Owner / Operator Retail Stores 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arthur B. White Ethel I. Schulz 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norma White (Daughter) 1608 Dryden Way, Crofton, Maryland 21114 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Cedar Hill Cemetery 4/11/2009 4 □ Donation 5 □ Other (Specify) Suitland, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility RAusch Funeral Home, P.A. P. O. Box 600, Lusby, Maryland 20657 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Liver **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 610 en Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the as 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 2 □ No the detached 9□Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 2**⊠**No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA this filled by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 1 Natural 2 Accident 5 Pending investigation To the Hospital or Attendi within 24 hours after death. To the Funeral Director A 1 ☐ Yes 2 ☐ No death. 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 0052242

DHMH 17 Rev 1/2001

State Registrar

JEW) 5

J. JOhn Barth, III MD 110 Hospital Rd., Suite 310, Prince Frederick, MD 20678

30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print)

APR 08 2009

32. Registraris Signature

31. Date filed (Month, Day, Year)

	1 - For State Registrar		rato or me	ar y tarra r .		ment of H ficate of L		Montai	Reg. No		9	1325
Physician	1. Decedent's Name (Firs			TTDD				2. Date		Z Ž	ar	3. Time of Dea
/Medical	4a. Facility Name (If not in	ary Cath		HIPP	4	b. City, Town, or	Location of Dea	ith The	40	. County of D		J.J.
Examiner	Washington	_	ospital			Hagers			1	Washin	-	
-uneral Director	5. Social Security Number 214–42–2136		7. Ag	e (In yrs. last bii 64		f Under 1 Year Months Days	If Under 24 Hr Hours Mir	8. Date (Mogi	of Birth Day Year 1 20,1	944 N	Country.	ce (State or Fo
show		County		10c. City, Tow		ion					100	d. Inside City L
ritems 23a or 28a-fs for roust be notified Funeral Director	10e. Street and Number 102 South W	_	Avenue	Tunkse		10f. Zip Code	21734	<u></u>	10g. C	itizen of Wha		y?
by B	3 ☐ Widowed 4 ☐ [Married	Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:			s Decedent of Hes, specify Cuba	ispanic Origin? In, Mexican, Pue Specify:	(Specify Yes erto Rican, etc	or No-	14. Race - A Black, V	Vhite, etc	
ner than "nature It, Inc. Natical E Completed	15. [(Specify on Elementary/Secondary	Decedent's Educat ly highest grade co (0-12)	ion ompleted) College (1-4or 5		(Give kir life. DO	nt's Usual Occup nd of work done of NOT use retired	ation during most of w l)	orking		Kind of Busin		
Con Con	12		0		home	maker	18. Mother's N	ame (First M		er own	hon	ne
ed oth even even	17. Father's Name (First,	yson W.	Warrenf	eltz			TO. MOTHER 2 IV	Naom:				
7 Is marke traumatic To	19a. Informant's Name/F James B. Wh	Relationship (Type	. Print)	19	b. Mailing	Address (Street	and Number or I	Rural Route l Avenue	Number, City	or Town, Sta	ate, Zip (Man	Code)
t: If item 2 y or other	20a. Method of Disposition 1 □ Burial 2 ဩ Cre 4 □ Donation 5 □	on emation 3 ☐ Ren		20b. Place o	of Dispositi ery, crema	ion (Name of tory or other place	e) Apr	Date i1 13, 2009	² 20c. l	Location - Cit	y or Tow	
Importan any Injur once.	21. Signature of Funeral		Spin	nager	22. 1	Name and Addre	ss of Facility	Minni	ch Fun	eral H	Home	
physician and street the burial-transit street burial-transit sedical Examiner	resulting in death) Last	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										
for use a		inant		e of pregnancy 2 ☐ Fetal deat at time of death		Ectopic pregnand Other (specify)	ey			23d. Date of Month		ry Day Yea
be d	artii. Other argininoani	t conditions contr	ibuting to death I	but not resulting	in the und	erlying cause giv	ren in Part I.	23e				e cause of dea
ate has								-	Was an autopsy performed?	' dea	ere autop or to con ath?]Yes	osy findings av npletion of cau 2 No
ector Be	25. Was case referred to examiner?		spital:	tient 2 🗓 ER/0	Dutnotiont.	3 DOA Oth	26. Place of D			6 ☐Other	(Specify	<u> </u>
ter this reral di	27. Manner of Death	☐ Pending	28a. Date of Inj (Month, D	iury 28b	. Time of Injury	28c. Inju Wor				jury occurred		/
al Director: After this of the din by the funeral dir	2 Accident 3 Suicide 6 4 Homicide	investigation Could not be determined	28e. Place of Ir building, e	njury - At home, etc. (Specify)	farm, stree			28f. Loca City	ation (Street or Town, Sta	and Number ate)	or Rurai	Route Numbe
within 24 nous aren usan. To the Funeral Director: Af completely filled in by the fur Medical Certification		Certifying Physic Medical Examine	cian: To the bes er: On the basis and manner s	of examination	lge, death and/or inve	occurred at the t estigation, in my	ime, date and pl opinion, death o	ace, and due ccurred at the	to the cause e time, date a	e(s) and man and place, an	ner as st	tated. the cause(s)
Comple	29b. Signature and title	of certifier				29c. Licen	se number		29d. l	Date signed ((Month, I	Day, Year)
18	30. Name and address	of person who com	npleted cause of	death (Item 23a	a) (Type, P	rint)	6611		21	7113	10 *)
8	Dr Au,	368 m	nil ST	ROET,	Itee	persto	on,	MD	2	170		
		ay, Year)	22 Phain	trar's Signature								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Virginia Lee Winner 2009 10:45 A M April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 915 Pine Trail Arnold Anne Arundel Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 115-16-8036 1 M 2 X 88 Director Jan. 8, 1921 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it a flood Examiner must be notified at Maryland Anne Arundel Annapolis 1 ☐Yes 2XNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1517 Circle Drive 21409 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 📉 Xo Specify. þ Specify 3 ☐ Widowed 4 ☐ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any linjury or other traumatic evonce. William B. Adams Marie Louise Edwards ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Winner/husband 1517 Circle Drive Annapolis, Maryland 21409 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Baltimore Crematory 4/10/2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Tuneral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Myocardial Infarction Minutes disease or condition resulting in death) /Medical Due to (or as a consequence of): Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Year 1 Tyes 24 XNo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be Daughter's home 26. Place of Death (Check only one) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 ☐ Pending investigation 1 🔀 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 □ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Medical f Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760. Division of Vital Records, P.O. within 24 hours after deat To the Funeral Director:

the Maryland

death with

"natural", or items 23a or

2 should be filed within 72 hours after and Mental Hygiene.

s marked other than "natural", or ite

Baltimore, Maryland 21215-0036

State Registrar

After

James Chaconas, MD 31. Date filed (Month, Day, Year)

(Check only

29b. Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1509 Ritchie Highway 32. Régistrar's Signatur

Arnold, Maryland 21012

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D16964

29d. Date signed (Month, Day, Year)

April 7, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	State of Marylar		rtificate of E		nemai riye	Reg. No 20)9	132	56
	Physici		1. Decedent's Name (First, Middle, La. Donald K. Whit					2. Date of Dea Month March	Dav	Year 009	3. Time of 1 9:50	Death A ^M
	/Medic Examir		4a. Facility Name (If not institution, giv La Casa Assisted			4b. City, Town, or l	Location of Death		4c. County of		undel	
	Funeral Director		201-42-3221	7. Age (In yrs. 91	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Aug. 29	, Year)		olace (State or otry) corgia	^r Foreign
	Maryland a-f show	ctor	Usual Residence of Decedent 10a. State Maryland Anne A		ty, Town or Lo		∞lis			1	0d. Inside Cit 1 ☐ Yes	100
	th with the 23a or 28	ral Dire	10e. Street and Number 7101 Bay Front Dr	ive #308		10f. Zip Code	21403	1	10g. Citizen of W	hat Cour. S.A.		
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, If a Modical Examican must be rediffed at once.	Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3★★ idowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1\2\2\2\4\5\2\10\8\8\9\8\10\8\10\8\10\8\9\8\9\8\9\8\9\8\9\8\9\8\9\8\9\8\9\8\		Was Decedent of His If Yes, specify Cubar 1 □Yes 22 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race Black Specify:	, White, פ	can Indian, etc. nite	
21215-0036	in 72 ho	oletec	15. Decedent's Ed (Specify only highest gra	ade completed)	(Give	dent's Usual Occupa kind of work done do DO NOT use retired)	uring most of work	ing	16b. Kind of Bu	siness/Inc	dustry	
	ed with ygiene. er thar	Com	Elementary/Secondary (0-12)	College (1-4or 5+)		Co-Owner			Educati		l Techr	ology
Maryland	uld be filk Mental H irked oth	To Be	17. Father's Name (First, Middle, Last, Charles Walker				18. Mother's Nam Jennie I			")		
	ind 2 sho alth and I 27 is ma er trauma	1	19a. Informant's Name/Relationship (Barbara Holcomb/	Type. Print) daughter		ng Address (Street a Box 5457				State, Zip 2140 3	_ ′	
Baltimore,	Pages 1 annent of He ant: If item ury or othe		20a. Method of Disposition 1 ☐ Burial 2XXCremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification of the content o	Removal from State		osition (Name of matory or other place e Cremato		Date /2009	20c. Location - (nd
Balt	permit. Depart Import any Inj once.		21. Signature of Funeral Service Licer	P. Katt		2. Name and Address 47 Duke of						401
68760,	hiticate be executed with principle of the burial-transit as the b	ical Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. LONCO	quence of):	TIVE						eath
O. Box	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregpant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	aldeath 3	☐ Ectopic pregnancy ☐ Other <i>(specify)</i>			23d. Date Mor			'ear
rds, P.	quires that in signed build be deta	þ	Part II. Other significant conditions	contributing to death but not res	sulting in the u	inderlying cause give	n in Part I.	23e. Did to	es 2 N	ibute to th		eath? Jnknown
Il Records,	The law requir cate has been s page 2 should	Completed						24a. Was a autop perfor 1 □ Yes	sy p me _k d? d		ppsy findings a mpletion of ca	
Vital	hysiclan ; The la his certificate ha I director, page 2	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐	1 EB/Outpatio	Otho	26. Place of Deat	th <i>(Check only or</i>		// / / / / / / / / / / / / / / / / / / /		sted
Division of	To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral d	Certification: To	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 2 Homicide 5 Pending investigation 6 Could not be determined	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	of 28c. Injury Work' M 1 □ Y		28d. Describe h	ow injury occurre	ed		
	ne Hospit n 24 houn ne Funera	Medical C		nysician: To the best of my kn miner: On the basis of examin and manner stated.								
	To th within To th	Me	29b. Signature and title of certifier	Mh		29c. License	number 0 6 3	145	29d. Date signed	(Month,	Day, Year)	9
2	OHCH	-	30. Name and address of person who	NECAL		0 4 1	>161	TAL	DR.	LI	WTH	11001
	Sta Registi		31. Date filed (Month, Day, Year) APR 01	32. Registrar's Sign	A.	pare						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene,

Certificate of Death

Reg. No. 1

			For State Registrar	State of Maryland /		tificate of L			Reg. No.	009	13257
	- · · · ·		Decedent's Name (First, Middle, Last)		V/4/00/V			2. Date of Dea	ath	Year	3. Time of Death
	Physicia /Medic		Betty Jewe		Villia			April 1	3,2009		4:45 Ам
7	Examin	er	4a. Facility Name (If not institution, give str 5103 Sharon Road	reet and number)		4b. City, Town, or Temple H	Location of Death			ounty of Death	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last	birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da 11/25/19			hplace (State or Foreign
	Director	,	007-26-5741	M 2 🖾 F 81	Yrs.	Wortens Days	Hours Will.	11/25/19	27		Maine
	land ow if	}	Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Loc	ation					10d. Inside City Limits
	a-fsh	ctor	Maryland Prince Georg	ge's Te	mple H	fills					1 □Yes 2 toto
÷	or 28	Director	10e. Street and Number			10f. Zip Code 20748			10g. Citize	en of What Cou USA	untry?
ŧ	eath w	Funeral	5103 Sharon Road	2. Was Decedent Ever in U.S.	13. V		ispanic Origin? (Sp	ecify Yes or No	- 14	. Race - Ame	rican Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Medical Examinar must be notified at once.	by Fun	1 ☐ Never Married 2 ☐ Married 3 ◯ Widowed 4 ☐ Divorced	Armed Forces? 1		Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto Specify:	Rican, etc.)		Black, White Specify:	o, etc. White
2-0	/2 hou	Completed	15. Decedent's Educa	ation 1	6a. Deced	ent's Usual Occupa	ation during most of work)	ina 1	16b. Kind	of Business/I	Industry
121	within she.	mple	Elementary/Secondary (0-12)	College (1-4or 5+)		00 NOT use retired les Clerk)		Re	etail	
0 2	filed v Hygie other 1	Be Co	17. Father's Name (First, Middle, Last)			las cient	18. Mother's Name	e (First, Middle,			
/lan	uld be Menta arked atic ev	To B	William Henry 1	Millett			Mary	Brun	n		
Var	2 sho h and 7 Is ma trauma		19a. Informant's Name/Relationship (Type Wendy Whytsell / Daugh	,			and Number or Rur ud Temple Hi			Town, State, 2 20748	?ip Code)
ē,	f Healt F Healt tem 2		20a. Method of Disposition			sition (Name of patory or other place		Date		ation - City or	Town, State
E .	Pages nent o int: If I		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)		s Crem		4/14/20	009	Edge	ewater, 1	Maryland
Baltimore, Maryland 21215-0036	permit. Departr Importa any Inju		21. Signatur Funeral Service Lengue	1		. Name and Addres	ss of Facility Ge 11. Road Oxo	eorge P. I on Hill, I	Kalas 1 Maryla	Funeral l nd 207	
	v		23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one	ations that caused the death. [o not ente	er the mode of dyin	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	hysician	n i	Immediate Cause (Final disease or condition resulting in death)	V C.	0	- (?					Criset and Death
	/Medical Examiner			Due to (or as a consequen	ce of):	238					
	it d	iner	Sequentially list conditions, if any, leading to immediate cause. In the United Sequence (Disease or injury	Due to (or as a consequen	ce of):						
	xecute and I-trans	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a consequen	ce of):			_			
68760,	ricate be executed I physician and s the burial-transit	edical E	d.								
89	ing ph	Medi	IF FEMALE:						- [
Box	Ine law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months?	 c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deat 9 ☐ Unknown 	ath 3	Ectopic pregnanc Other (specify) _	у		23	3d. Date of del Month	lvery Day Year
P.0.	ures that the de signed by the a d be detached to	Phys	9 ☐ Unknown Part II. Other significant conditions cont		og in the ur	derlying cause give	en in Part I	23e. Did t	obacco usi	e contribute to	the cause of death?
ds,	urres tr signe Id be d	d by	Fait II. Other significant conditions cont	mouning to death out not resum	ig in the ur	denying oddoo giv	on mer die n	,142			robably 4 Unknown
COL	sw requir s been si s should b	Completed						24a. Was	an	24b. Were au	itopsy findings available completion of cause of
<u> </u>	The law ate has page 2 s	omi						autoj perfo 1 □Yes	ormed?	death?	2 No
Vita ∶	ician: sertific ector,	Be (25. Was case referred to medical examiner?	ospital:		• a 🗆 DOA Oth	26. Place of Deat		_		
to i	ding Physician: The Inc. h. After this certificate h. funeral director, page	5	1 ☐ Yes 2 🖾 No	28a. Date of Injury 28	b. Time of	1 3 L DOX	4 LI Nursing no	ome 5 Resi 28d. Describe			cify)
on :	Attending Physician: r death. sector: After this certifica by the funeral director, p	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day, Year)	Injury		ć? Yes 2 □No				
		Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, stre	eet, factory, office		28f. Location (City or To	Street and wn, State)	Number or Ru	ural Route Number,
	Fun Flor	Medical C	29a. Certifier (Check only one) Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifier	ician: To the best of my knowle er: On the basis of examination and manner stated.	edge, death	occurred at the tile vestigation, in my o	me, date and place opinion, death occur	, and due to the rred at the time,	cause(s) a date and p	and manner a place, and due	s stated. e to the cause(s)
	To the within 2 To the соттре	Me	29b. Signature and title of certifier	A		29c. Licens	e number	A :	29d. Date	signed (Mont	h, Day, Year)
	,		100	~ 100			596	4	4	1131	04
	5		30. Name and address of person who cor Barry Red jas				01 Temple	Hills.			
	01-	ite	31. Date filed (Month Day, Year)	32. Registrar's Signature							

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 4:50 P M INSKIP WAITE APRIL 2009 6 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** PRINCE GEORGE'S HOSPITAL CHEVERLY PRINCE GEORGE'S If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Days Hours 11 M 2 □ F 767-66-8097 72 OCT. JAMAICA 1936 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County show s 23a or 28a-f short Y☐Yes 2☐No Directo MD PRINCE GEORGE'S HYATTSVILLE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 705 TOLA COURT 20785 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status event, the Medical Examiner. 1 ∐Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 6 1 ☐ Yes 2 ☐ No BLACK Specify: \$ 3X Widowed 4 □ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) other than Elementary/Secondary (0-12) 12TH CONTRACTOR 2 YRS PRIVATE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) h and Mental I æ ARNOLD GEORGE SYLVESTER WAITE TRTS DAVIS ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a SHARMAINE JACKSON/DAUGHTER 705 TOLA COURT HYATTSVILLE, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ₹ permit. Pages Department of Important: If it any Injury or or 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State RIVERDALE CREMATORY 4/11/2009 RIVERDALE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 21. Signature of Fundamerice Lic 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician ACUTE RESPIRATORY FAILURE resulting in death) /Medical Due to (or as a consequence of) Examiner PNEUMONIA Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed CEREBROVASCULAR ACCIDENT attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760 Physician/Medical HYPERTENSION IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a ☐Yes 2☐No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown DIABETES MELLITUS should has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has be rector, page 2 s performed? Yes 2 No 2 🖾 No 1 ☐ Yes 1 ☐ Yes uneral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 ☑ Natural s after death.

I Director: A
d in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \(\text{Homicide} \) filled 24 hours a 29a. Certifier 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

To the Fune

completely fi Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number APRIL 8 2009 D21883 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar YADIA M.D.

HEMA P.

DHMH 17 Rev 1/2001

Registrar's Signa

9470 ANNAPOLIS ROAD SUITE 315 LANHAM, MARYLAND 20706

State of Maryland / Department of Health and Mental Hygiene

		•	1 - State Registrar				(Certii	ficate of l	Death		Reg. No.	<u> 2009</u>) [3]	259
	Physicia	an	1. Decedent's Nam								2. Date of De Month	Day		3. Time of	
	/Medic		FRANCIS	ELWOOD	AYTON,				. O' T		April	23,			a ^M
	Examin	er	4a. Facility Name (I					41	b. City, Town, or Bowie	Location of Death	1		County of Dea	m George's	
	Funeral		5. Social Security N		. Sex		n yrs. last birth		f Under 1 Year	If Under 24 Hrs.	8. Date of Bir	th	9. Bir	thplace (State	
	Director		212-68-58	808	1 M 2 □ F	5.3	3 Yı	s. N	Months Days	Hours Min.	Dec. 1	5, 1	955 Ma	ountry) aryland	
	pu .		Usual Residence of	Decedent 10b. County		10	c. City, Town	or Locati	ion					10d. Inside C	ity Limits
	laryla f shor	o			C			DI EUCATI	1011						2 □ No
	the N	Director	Maryland 10e. Street and Nu		George	S	Bowie		10f. Zip Code			10g. Citi	izen of What C		
:	3a or		2956 Nove		urt, No	rth			2071	6		U.	S.A.		
	death	Funeral	11. Marital Status		12. Was De Armed I	cedent Ever	r in U.S.	13. Was	s Decedent of H	lispanic Origin? (S an, Mexican, Puerto	pecify Yes or No)-	14. Race - Am Black, Whi		
0000	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I fire X7 is marked other than "natural"; or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be notified an once.	þ	1 ☐ Never Marr 3 ☐ Widowed	ied 2☐ Married		2 □ No Give			Yes 2XXXIo	Specify:	o riloan, cic.,			white	
0	72 hor	Completed	(Spec	15. Decedent's		()	16a. E	eceden	t's Usual Occup	nation during most of work	kina	16b. Ki	ind of Business	/Industry	
7	ithin /	mple	Elementary/Seco		College	(1-4or 5+)		ife. DO	NOT use retired	d) -	Mily		Home		
V .	Hygie Hygie Her ti		17. Father's Name	(Eiret Middle Is	2 ye	ars	Su	per:	intende	18. Mother's Nam	ne /Firet Middle		Surnamel	on	
מב	d be f ental l ced of	Be C	Francis			r.					ice F. S	_	ŕ		
_	shoulk nd Me mark imatik	욘	19a. Informant's N		<u> </u>		19b. I	Mailing A	Address (Street	and Number or Ru				Zip Code)	
<u> </u>	alth a 27 is		Sharon L	. Hale	/ comp	anion	29	56 1	Novembe	r Court,	North	Bowi	e, Mary	land 2	20716
ย์	of He of He litem		20a. Method of Dis			- 1	20b. Place of E	Disposition of the cremate	on (Name of ory or other place	ce)	Date	20c. Lo	ocation - City o	Town, State	
altimor	Pag ment ant: I ury o			☐ Cremation 3 5 ☐ Other (Spe		n State	St. Jo			opal Apr.			eltsvil	lle, MD	
ם ב	permit. Depart Import any Inj once.		21. Signature of F	moral Service Lie	censee	/ M007	770	22. N Do 3.	lame and Addre onaldson 13 Talbo	ss of Facility n Funeral ott Avenu	Home, le Laur	P.A.	Marvlar	ad 2070	7
П			23a. Part 1. Enter t shock, or hea	the disease, or co	omplications tha	t caused the	death. Do no						2	Approximat	le tween
· P	hysician	r M	Immediate Cause	(Final			atic Me							Onset and 8 Mont	Death
	/Medical		resulting in death)	4	Due t	o (or as a co	onsequence of):							
	Examiner	Ļ	Sequentially list co	nditions,	b	,									
	ted nsit	nine	Sequentially list co if any, leading to in cause. Enter U co Cause (Disease or that initiated events	mediate silying injury	Due t	o (or as a co	onsequence of):							
	execu n and al-trai	Examiner	that initiated events resulting in death)	s Last	c Due t	o (or as a co	onsequence of):							
00/00	eath certificate be executed attending physician and for use as the burial-transit				d										
0	ng ph as th	Medical	IF FEMALE:									- 1			
-	0 = 0		23b. Was deceden		23c. If yes, c	e birth 2 🗆	Fetal death	3 □ E	ctopic pregnanc	ey .			23d. Date of d		Year
5	I he law requires that the death ate has been signed by the atter bage 2 should be detached for u	Physician	in the past 12 1 □ Yes 2 l 9 □ Unknown		4 □ Pre 9 □ Un	egnant at tim known	ne of death	5 □ 0	ther (specify) _				WOTH	Day	7041
Γ.	e law requires that the dr has been signed by the le 2 should be detached		Part II. Other signi	ficant condition	s contributing to	death but n	ot resulting in t	he unde	erlying cause giv	en in Part I.	23e. Did	tobacco	use contribute	to the cause of	death?
Hecords,	quires in sigr	d by									1 🗆	Yes 2	□ No 3 □ f	robably 4X	Unknown
ည	sw rec	olete									24a. Was			utopsy findings	
ב י	The la	Completed									auto perf 1 □ Yes	opsy ormed? 2 X∷X No	death?	completion of o	ause of
VICE I	aing Physician: The h. After this certificate h funeral director, page	Be	25. Was case reference examiner?	rred to medical						26. Place of Dea					
5	hysic this c al dire	၉	1 ☐ Yes 2X				2 ER/Outp			4 🗀 Nursing n	lome XXRes			ecify)	
SION	ding 1	ion	27. Manner of Deat	ın 5	(Mi	te of Injury onth, Day, Ye	ear) 28b. Tii	ne or ury	28c. Injui Wor	ryat k? Yes 2 □ No	28d. Describe	now injui	ry occurred		
	Atten deatl ctor: y the	fical	2 ☐ Accident 3 ☐ Suicide	6 ☐ Could no determin	t be 28e. Pla	ce of Injury	- At home, farn	n, street		1163 2 110	28f. Location	(Street ar	nd Number or I	Rural Route Nur	nber,
5 .	al or safter	Certification:	4 ☐ Homicide	GOTOTTINI	bui	lding, etc. (8	Specity)				City or To	wn, State	9)		
:	or the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, p	Medical (29a. Certifier (Check only one)	Certifying	caminer: On the	he best of me basis of ex anner stated	amination and	death o	ccurred at the ti stigation, in my	me, date and place opinion, death occu	e, and due to the urred at the time	e cause(s , date an	s) and manner d place, and de	as stated. ue to the cause(s)
1	Vomp	Me	29b. Signature and	tifle of certifier	1				29c. Licens	se number		29d. Da	ate signed (Moi	nth, Day, Year)	
	,		1 Open	1 7HM	1 m.o	,			D0	064160		Apr	il 24,	2009	
1	0 1		30. Name and add		o completed ca							-			
	~		Azriel 31. Date filed (Mor	Hirschi		S. G.	reene S	tre	et, Ba	ltimore,	Marylar	nd 2	21201		
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April 20 pay **Physician** 2009 9:23 ам BERTHA KATHERINE BRADBERRY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Prince George's Laurel Regional Hospital Laurel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Yea July 2, 1 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□M 2√X West Virginia 215-74-7665 69 1939 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show ? Is marked other than "natural", or Items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at Director Prince George's Laurel Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20707 USA 925 Montgomery Street Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X Valo if Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 72 hours after 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2/∑XNo Specify White þ 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Grade 10 Homemaker permit. Pages 1 and 2 should be filed 1 Department of Health and Mental Hygic Important: If item 27 is marked other t any Injury or other traumatic event, th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Willard Wilson Marie McClanahan ္က 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harry Bradberry 925 Montgomery Street Laurel, Maryland 20707 son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2XX remation 3 ☐ Removal from State West Arundel Crematory 4/29/2009 Odenton, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility
Donaldson Funeral Home, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, priveart failure. List only one cause on each line.

Immediate C ise (Final disease or condition resulting in death)

a. Sepsis 313 Talbott Avenue Laurel, Maryland 20707 Approximate Interval Between Onset and Death Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-tran Due to (or as a consequence of) P.O. Box 68760, physician The law requires that the death certificate be Physician/Medical the 1 use as IF FEMALE 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day ō in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed to 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Nhknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed certificate 1□ Yes 2√√No 1 Yes 2/JXN0 the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2**(**No XXInpatient 2 ER/Outpatient 3 DOA 1 Yes Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1XXXII atural 1 ☐ Yes 2 ☐ No 2 Accident by the after death Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide filled in I 24 hours a 1 X crifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 12067210 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kunis KNIKBAS 400 West 7th Street Frederick, Maryland 32 Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

APR 27

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month Physician 9:55 4M 2 avenia A. Blezler 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore N/A Hospital Harbor If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) Social Security Number Funeral Days Hours 1 ☐ M 2 M F Months 213-01-9702 91 Dec. 16, 1917 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 28a-f show at 1 ☐Yes 2 No Brooklyn Park Maryland Anne Arundel notified Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or Items 23a or in yor other traumatic event, the Medical Examiner must be a 21225 U.S.A. 318 West: Arundel Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 11. Marital Status 1 Never Married 2 Married White 1 ☐ Yes 2 No altimore, Maryland 21215-0036 Specify. þ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Daniel Sherman Green Sousanna Henkle ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1909 Pometacom Drive, Hanover, Maryland 21076 (Son) Donald Spencer 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 04-25-09 Cedar Hill Cemetery Brooklyn Park, Maryland 22. Name and Address of Facility
McCully—Polyniak Funeral Home P.A.
237 East Patapsco Avenue, Baltimore, Maryland 21. Signature of Funeral Service Licenses 21225 Per . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death lemi ediate Cause (Final disease or condition resulting in death) Iday Sepsis Physician 1410805 /Medical Due to for as a consequence of): Infection / Dehydration Examiner Tract wech Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician s the buria by Physician/Medical as attending plant of the season IF FEMALE: yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 □ Ectopic pregnancy Month Year in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 ☑Unknown 1 □ Yes 2 □ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an has autopsy performed 2 No 20 certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 1 ☐ Yes 1 Inpatient 2 No 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) P this 27. Manner Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After t 5 ☐ Pending investigation Injury To the Hospital or recommend to the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

Saloib

31. Date filed (Month, Day, Year)

Mohin

3001 South Honover Steet, Baltimore, Maryland 21225 32. Against & Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 04 200 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) izabeth 130 enter timor Birthplace (State or Foreign Country) Year If Under 24 Hrs. If Under 8. 7. Age (In vrs. last birthday) Year Months Days Hours 1 □ M 2 🔀 F 91 28. 1917 Maryland Nov. 220-03-8569 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 XYes 2 □ No Baltimore Maryland N/A 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21230 Apt. 215 600 Light Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 □Yes 2 No Specify: White If Yes, Give Year or Dates Specify: 3 A Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Giaovanna Bonanno Bianca Angelo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 224 Altamont Avenue, Catonsville, Maryland 21228 F. Michael Blair (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Bayview Crematory 04-25-09 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22: Namy and Address of Facility Your Ly-Polyniak Funeral Home P.A. 130 Fast Fort Avenue Baltimore, Maryland 21230 21. Signature of Funeral Service Licens 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, inches, or heart failure. List only one caus, on each line. Insteadiate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): Approximate Interval Between Onset and Death ears Duy to (or as a consequence of): XIa Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last en Urr Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 3 🗆 Ectopic pregnancy Year Month Dav 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown elmonia 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? res 2 No 2 No nem 1 TYes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical Examiner

Physician

/Medical

Examiner

10a, State

Funeral

Director

ir items 23a or 28a-f show ili er inust be notified at

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d other than "natural", or

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, ID-4 M pones.

Director

by Funeral

Completed

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the Maryland

Pages 1 and 2 should be filed within 72 hours after death with

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached fin use as the hurial transition.

Division of Vital Records, P.O. Box 68760,

Examine Physician/Medical ģ Completed Be (Certification: To

9 Unknown 2 No 1 ☐ Yes 27. Manner of Death

23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No

1 Natural
2 Accident

3 ☐ Suicide

29a. Certifier

cal

4 ☐ Homicide

1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? Injury (Month, Day, Year) 1 ☐ Yes 2 ☐ No

5 ☐ Pending investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

29c. License number

K Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

212

galise of death (Item 23a) (Type, Print) 30. Name and address of person who complete Benson 3320 Avenue Vimp

31. Date filed (Month, Day, Year)

32. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** nomas April 2009 4:00P 6, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Memorial Hospital Havre de Grace Harford If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1⊠M 2□F 216-52-0597 58 Director Nov. 20, 1950 | Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show ?7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Modell Even, in a few nothers Director 1 ☐ Yes 2 ☑ No Md. Baltimore Dunda1k 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1200 Hillshire Road 21222 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 76 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Yes 2 I If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 12 should be filed within 72 h and Mental Hygiene. **7 is marked other than "n**. Elementary/Secondary (0-12) 12College (1-4or 5+) Santoni's 4 yrs Controller 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Daniel C. Czawlytko Edwina DeChriste 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other trau Edwina Czawlytko (Mother) 1200 Hillshire Road Dundalk, Md. 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1

Burial 2 □ Cremation 3 □ Removal from State St.Stanislaus Cem 4-29-2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Kaczorowski Funeral Home, P.A. 21. Signature of Funeral Service Licensee Rober 1201 Dundalk Avenue Baltimore, Md. 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) umonio **Physician** /Medical Dik to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): sician and burial-trans Due to (or as a consequence of) P.O. Box 68760, the attending physician Physician/Medical nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy **To the Funeral Director:** After this certificate has been signed by the atte completely filled in by the funeral director, page 2 should be detached for i in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🙀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 ☐Yes 2 🙀 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 200 No 10 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) Hospital or Attending Ph 24 hours after death.Funeral Director: After tr 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examíner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 00 63220 GEORGE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UNTON AVE SOMTH 0 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

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Inorna

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 13264 2009 Naomi T. Cook Certificate of Death 1- For State Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 0740 hrs April 11, 2009 Naomi Ta-Sheila Dionti'e Cook Medical Examiner 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) Prince George's Cheverly Prince George's Hospital Center 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number Wash DC **Funeral** Min Months 4/30/1977 Director 577-82-4137 M 2X F 31 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County any Yes 2 No Washington, DC ; 23a or 28a-f show ; notified at once. Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country 10e. Street and Number USA 20001 apt.#203 1323 5th Street N.W. 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? Never Married 2 Specify:Black Yes 2 x No Yes 2 X No specify: If Yes, Give Year Widowed Divorced 16b. Kind of Business/Industry ş 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) homemaker timore, MD 21215-0036 domestic 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Vera Cook Herman Washington 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 0747 5237 Hilmar Drive, District Heights, MD Vera G. Mitchell (mother) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) Burial 2 X Cremation 3 Removal from State 5/1/2009 Beltsville, MD. Chesapeake Crem. Donation 5 Other Specify 22. Name and Address of Facility 420 H St.NE. . Six ne ture of Fung al Service Licensee B.K. Henry Funeral Home DC.20002 Wash M01178 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interva Between Onset and Physician failure. List only one cause on each line Death Medical a Multiple Gunshot Wounds Immediate Cause (Final disease .aminer Due to (or as a consequence of): or condition resulting in death) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cauce. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last that the death certificate be executed and Physician/Medical UNPENDED AMENDED ending physician use as the burial -23d, Date of delivery Records, P.O. Box 68760. 23c. If yes, outcome of pregnancy IF FEMALE: Year Day Month 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 🗸 Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions 1 Yes 2 V No 3 Probably 4 Unknown þ The law requires 24b. Were autopsy findings available Completed 24a. Was an prior to completion of cause of autopsy performed' death? certificate has bector, page 2 sh ✓ Yes 2 1 V Yes Nο 26.Place of Death (Check only one) · Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical Division of Vital Be Residence 6 Other_A Hospital: 1 / Inpatient 2 Nursina Home 5 examiner? ER/Outpatient 3 this 1 ✓ Yes 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury After t 27. Manner of Death Subject shot Certification: Apr 11, 2009 0255 hrs Yes 2 V No Natural Pending Director: 28f. Location (Street and Number or Rural Route Number, City Investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be or Town, State) 3816 Regency Parkway #202, Suitland, MD 3 Suicide (Specify) Multi-Family Apt. 4 V Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical To the and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier April 12, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Ana Rubio MD.

31. Date filed (Month, Day, Year) State Registrar

32. Redistrar's Signature ORIGINAL

BUIVE

State of Maryland / Department of Health and Mental Hygiene

Physician /Medica Examine

Funeral Director

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be redified at once. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit State

	•	1 - State Registrar			Ce	rtificate of l	Death	,	Reg. No.	2009	13265
Physicia	an	1. Decedent's Name (First, Middle						2. Date of De	eath Day	Year	3. Time of Death
/Medic		IRENE CAMPAGN	NA					April		2009 Year	11:00 p ^M
Examin	er	4a. Facility Name (If not institution					r Location of Death			County of Deatl	
		Greater Laurel				Laure		0.01.40			George's
uneral irector		5. Social Security Number 180-01-3833	6. Sex 1 □ M 2 □ F	7. Age (In yrs. I	ast birthday Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D Oct 2,	ay, Year)	Co	hplace <i>(State or Foreign</i> untry) nsylvania
W		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or L	ocation					10d. Inside City Limits
sho	'n					o cattori					1∏Yes 2□No
28a-f	Director		e George'	S L	aurel	10f. Zip Code			10a Citi	zen of What Co	
20.2	ă	10e. Street and Number	!								unity:
s 23	e a	1108 Marton Str		edent Ever in U.	C 10	20707	lia-onio Origina (Ca	acifu Von or N		S.A. 14. Race - Amei	ricon Indian
item F	Funeral	11. Marital Status1 ☐ Never Married	Armed Fo	rces?	5. 13.	Was Decedent of H If Yes, specify Cuba	an, Mexican, Puerto	Rican, etc.)		Black, White	
al", or	ρ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Gir	ve		1 ∐Yes 2∛∭ZNo	Specify:			Specify: Wh	nite
natura lical E	Completed		nt's Education est grade completed)			edent's Usual Occup		rina	16b. Kir	nd of Business/I	Industry
an "i	nple	Elementary/Secondary (0-12)	College (1	I-4or 5+)	life.	DO NOT use retired	d)	ang			
her th		Grade 12	1		Home	maker	d O - Markharda - Name	- (First Middle		wn Home	
ever	Be	17. Father's Name (First, Middle, Louis Kovacs	Last)				18. Mother's Nam		e, maideri	ourname)	
natic	은	19a. Informant's Name/Relations	phin (Time Brint)		10h Mail	ing Address (Street	Mary Is:		har City o	r Town State 7	Zin Codo)
7 is r		Louis J. Campao		/ son							Land 20706
tem 2		20a. Method of Disposition	,,	20b. P	lace of Disp	osition (Name of	i	Date		cation - City or	
y or		XX Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		State		matory or other place. TS Cemete		/2009	Lai	urel, Ma	arvland
Department of from an world raygener in innortant if them 23 a or 28a-f show important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Modical Examinar must be redified at once.		21. Signature of Funeral Se vice				2 Name and Addre	es of Facility			22027 110	21,14114
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		23a. Part1. Enter the disease, o shock, or heart failure. List	r complications that of	aused the death	n. Do not er	nter the mode of dyir	ng, such as cardiac	or respiratory	arrest,		Approximate Interval Between
sician		Immediate Cause (Final disease or condition	4		ementi	a with Ps	ychosis				Onset and Death 3 months
ledical		resulting in death)	a	(or as a consequ							
aminer		Sequentially list conditions	b. Acu	te Occi	pital	Stroke					3 months
sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to	(or as a consequ	uence of):						
and I-tran	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a consequ	lence of):						
sician				(
g phy as the	Medical		u								
endin		IF FEMALE: 23b. Was decedent pregnant		tcome of pregna		☐ Ectopic pregnanc	NV		2	23d. Date of del	
he att	Physician	in the past 12 months? 1 □ Yes 24 □ No		nant at time of d		Other (specify)	,			Month	Day Year
d by letach	Phy	9 ☐ Unknown Part II. Other significant conditi	one contributing to d	eath but not resu	ulting in the	underlying cause giv	ren in Part I	23e Did	tobacco u	se contribute to	the cause of death?
signe d be c	þ	Hypertension	ons contributing to di	eath but not rest	anding in the	andenying cause giv	CITITI CITI.				obably 4 ☐ Unknown
been	etec	Hyperlipidemi	а							1	A
has ge 2 s	Completed		<u> </u>					24a. Was	psy		stopsy findings available completion of cause of
ificate or, pa		25. Was case referred to medica	al .				00 81 (8		ormed? 2 1 No	1 □Yes	2 🗷 😽
s cert lirecto) Be	examiner? 1 ☐ Yes 2 ☑ 🏋	Hoepital	Inpatient 2 🗆	ER/Outpatie	ent 3 🗆 DOA Oth	26. Place of Dea			Other (Coo	oif.)
eral d	n: To	27. Manner of Death	28a. Date	of Injury	28b. Time	of 28c. Injur	ry at	28d. Describe		3 ☐ Other (Spectron) y occurred	City)
r: Aft	atio	1 XNatural 5 ☐ Pendir 2 ☐ Accident investi	ng (Mon igation	th, Day, Year)	Injury	M 1 □	k? Yes 2□No				
recto by th	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	not be nined 28e. Place buildi	of Injury - At ho	ome, farm, s	treet, factory, office			(Street and		ıral Route Number,
ral Di											
The factors of the country of the certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit completely filled in by the funeral director, page 2 should be detached for use as the burial-transit completely filled in by the funeral director, page 2 should be detached for use as the burial-transit completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Medical		ng Physician: To the I Examiner: On the b and man								
To th	ž	29b. Signature and title of certifie	02	てらる		29c. Licens	se number		29d. Dat	te signed (Monti	h, Day, Year)
		- C	ozers Pr	2421C19	TN	D005	7216		Apri	1 24, 2	2009
\checkmark		30. Name and address of person		•	,						
Ě	to	Michael Baako, 31. Date filed (Month, Day, Year,	M.D. 3450	J F't. Me	eade R	oad, #209	, Laurel	, Maryl	and	20724	
Sta Registr		APR 27	2009 Cen	legistrar's Signa	40	the					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Dav Vear **Physician** /Medical City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** SEVERNA IVING NRIS If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb. 25, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 M F Months Days Hours Min. Maryland 89 215-03-5741 Director Feb. Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City. Town or Location 10a, State 10h County show ral", or items 23a or 28a-f shov 1 Yes 2 No Director Baltimore N/A Maryland 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code U.S.A. 21230 1614 Marshall Street Funeral Pages 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No White Specify Specify: Completed by 3 Widowed 4 □ Divorced 'natural", permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any injury or other traumatic event, the Medical Ang. Angles I SADE. 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Hame Homemaker 9 0 18. Mother's Name (First, Middle, Maiden Surname)

Hoppriotta Scheckles 17. Father's Name (First, Middle, Last) Be Henrietta Walton Daniel ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 264 Harlem Road, Pasadena, Maryland 21122 Catterton III (son) M. Clarence 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Cedar Hill Cemetery 04-27-09 Brooklyn Park, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
McCully-Polyniak Funeral Home 21. Signature of Funeral Service Licenses P.A. 237 Fast Patapsco Avenue, Baltimore, Maryland 21225 Approximate Interval Between Onset and Death 23a. Point. Enter the disease, or complications that caused the death. ock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, ling diate Cause (Final ease or condition resulting in death) OYONE **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any leading to infinite cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Physician/Medical Examiner Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □Yes 2 ☑No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Day Year been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No 2 12 No certificate 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) ASSISTED Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) LIVINE 1 | Yes 2 | ₩6 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 🗌 No 2 Accident Director; 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29c. License number 29b. Signature and title of certifie

State

State Registrar

APR 27 2009

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rom NIL

32. Registrar's Signature

Division of 24 hours Funeral To the 1 within 2

> State Registrar

DHMH 17 Rev 1/2001

F

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certilier

31. Date filed (Month, Day, Year)

JOGINDER



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Ata mil

29c. License number

29d. Date signed (Month, Day, Year)

TOWSON, MARYLAND

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 27,29a per phys., 250,04/27/09dhb Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Harry 11:30 am 2009 areal APRIL /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE SAINT AGNES HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) **Funeral** 319.38.1106 Usual Residence of Decedent Days 05.10 6 Director death with the Maryland 10c. City, Town or Location 10d. Inside City Limits if than "natural", or items 23a or 28a-f show Battimore 1 PYes 2 □ No Director 10g, Citizen of What Country? Street and Number by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Maryland 21215-0036 If Yes, Give Year or Dates: Specify Hack Specify: 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nt: If item 27 is marked other than "n. y or other traumatic event. If the market of t Elementary/Secondary (0-12) College (1-4or 5+) Mother's Name (First, Middle, Maiden Surname . Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Williams Carrol Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9a. Informant's Name/Relationship (Type. Print) S. Hilton St., Batt., MD 21239 Carroll (wife) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other) Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Battimore, MD permit. Page Department of Important: If any Injury or once. 04.07.09 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Waughy, C. Grasse Fure Pal Services re of Funeral Service Mensee 5151 Baltimore Nat? Pike (21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 2 O DAYS Immediate Cause (Final PNEUMONIA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): 6 YEARS Examiner ORONARY ARTERY DISEASE Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner 2 DAYS RENAL CUTIZ sician and burial-trans Due to (or as a consequence of) attending physician for use as the buria Z DAYS Box 68760 ACIDOSIS ACTIC Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No ed by the a o 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. INSUFFICIENC RENAL 2 No 3 Probably 4 Unknown LCHRONIC 1 ☐ Yes Completed HTN 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an director, page 2 autopsy performe SCH120 PHRENIA 1 ☐ Yes 2 XNo 1 ☐Yes 2 XNo Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \subseteq Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) Hospital: 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Division of 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Certification: Hospital or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 2 Accident o Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier APRIL 1. P23494 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 CATON AVENUE, BALTIMORE MD21249

State Registrar 31. Date filed (Month, Day, Year) APR 27 2009

MUHAMMAD



			I - State Amend Item State of Maryland Department of Health and No. 1 - State Pegistrar Certificate of Death	ental Hygier/ ا Reg	ne 2009 3269
	D1		1. Decedent's Name (First, Middle, Last)	2. Date of Death	3. Time of Death
	Physicia /Medic		CATHERINE A. DORTCH	03-23-20	
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	_	4c. County of Death
a diri			Washington Adventist Hospital Takoma Park 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8 Date of Birth	Montgomery 9. Birthplace (State or Foreign
	Funeral Director		577-70-3931 1 M 2 F 56 Yrs. Months Days Hours Min.	(Month, Day, Yea 03-07-19	ar) Country)
	p ,		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
	laryla shov	ō			1 ☑ Yes 2 ☐ No
	the N 28a-1 notifie	rect	Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code	10g.	Citizen of What Country?
	n with	al Di	10000 Brunswick Ave. #105 20910		USA
	ems ?	Funeral Directo	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. 1f Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	hours after death with the Maryland tural", or items 23a or 28a-f show at Examiner must be notified at	by Fu	1 _\text{YNever Married} 2 _ Married \\ 1 _\text{Yes} 2 _\text{YNo} \\ 1 _\text{Yes} 2 _\text{YNO} \\ 1 _\text{Yes} 2 _\text{YNO} \\ 1 _\text{Yes} 2 _\text{YNO} \\ 1 _\text{Yes} 2 _\text{YNO} \\ 1 _\text{Yes} 2 _\text{YNO} \\ 1 _\text{Yes} 2 _\text{YNO} \\ 1 _\text{Yes} 2 _\text{YNO} \\ 1 _\text{Yes} 2 _\text{YNO} \\ 1 _\text{Yes} 2 _\text{YNO} \\ 1 _\text{Yes} 2 _\tex		Specify: Black
21215-0036	be flied within 72 hours after death with the Marylan Hygiene. d other than "natural" or items 23a or 28a-f show event, the Medical Examiner must be notified at		15 Decedent's Education 16a. Decedent's Usual Occupation	16b.	. Kind of Business/Industry
212	filed within 72 Hygiene. other than "na ent, the Medic	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give kind of work done during most of work life. DO NOT use retired)		
	e filed wir al Hygien other th vent, the		12th Secretary		deral Government
_	l be fil intal H ed otl	Be	,	e (First, Middle, Maid J. Jones	en Surname)
2	2 should be and Menta Is marked aramatic ev	မ	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rui		ty or Town, State, Zip Code)
ž.	und 2:		Equesia T. Pitcher 7514 Eastern Ave., NW	Washingto	n, DC 20012
altimore,	es 1 s of He if item or oth		1 Neurisl 2 Cremetion 3 Removed from State cemetery, crematory or other place)		. Location - City or Town, State
Ě	t. Pag tment tant: I jury c		4□Donation 5□Other (Specify) Cedar Hill Cemetery 03-27	'-2009 Su	itland, Maryland
Ra	permit. Pages 1 and 2 should be Department of Health and Ments Important: If item 27 is marked any injury or other traumatic ev once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility May Heagman M0/374 Cedar Hill FH 4111	PA Ave.,	Suitland, MD 20746
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line	or respiratory arrest,	Interval Between
F	Physician		Immediate Cause (Final disease or condition resulting in death)		Onset and Death
art.	/Medical Examiner		Due to (or as a consequence of):	TIN 1100	101
		Je.	Sequentially list conditions, if any reading to three date. Exists for as a conversion pool of cause. Enter Underlying	W ICK	
	ocuted nd ransit	Examiner	Cause (Disease or injury that initiated events c		
8760,	icate be executed physician and the burial-transit	a Ex	resulting in death) Last Due to (or as a consequence of):		
/89	inficate g phys as the	edical	d		
Rox	th cer tendin r use	sician/Me	IF FEMALE: 23b. Was decedent pregnant In the part 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of delivery
о П	the dea y the at ched fo	ysici	in the past 12 months? 1		Month Day Year
v,	s that gned b e deta	y Phys	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?
Vital Records,	equire en siç ould b	ted t	- ena stage served auxax on acacyris	1 ☐ Yes	2 No 3 Probably 4 Junknown
ပ္တ	law r has be	Completed by		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
<u> a</u>	n: The ficate r, pag			performed 1 □ Yes 2 🐼	
5	sicial s certi lirecto) Be	examiner?	h (Check only one)	e 6 ☐ Other (Specify)
ō :	g Phy terthis nerald	n:T	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	28d. Describe how in	
j j	endin sath. or: Afi he fur	atio	2 Accident investigation M 1 Yes 2 No		
Division	l or Att after de Directe J in by t	Certification: To	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street City or Town, St	t and Number or Rural Route Number, tate)
:	To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death, within 24 hours after death, to the Funeral Director. After this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as	Medical C	29a. Certifier (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	, and due to the caus red at the time, date	ee(s) and manner as stated. and place, and due to the cause(s)
	To th Withir To th Comp	Me	29b. Signatule and title of certifier 29c. License number	Z 29d.	Date signed (Month, Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	7	0/2/1/1
			Nasreen Kango, MD 7701 Carroll Avenue, Takoma Park, M	aryland 20	0912
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's gignature APR 2 7 2009 Seven A. Facelone		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-02968 State of Maryland / Department of Health and Mental Hygiene Daniel Matthew Davis Certificate of Death Reg. No. 1- For State Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ 0903 hrs April 14, 2009 Medical Examiner DAVIS DANIEL MATTHEW 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Cheverly Prince George's Hospital Center 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Min Months Country) Wash . , DC March 18,1973 Director 36 1 X M 2 F 579-82-4102 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 X Yes 2 No Washington 28a-f show is 23a or 28a-f show se notified at once. D.C. death with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20019 5325 Bass Place S.E. #14 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S 11. Marital Status White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married 2 Yes 2 × No Black Specify: Yes 2 X No specify: If Yes, Give Year Divorced Pages 1 and 2 should be filed within 72 hours after Widowed "natural", 16b. Kind of Business/Industry ð 16a, Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Moving Company the Medical h and Mental Hygiene. 27 is marked other than Mover 21215-0036 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Kim Davis Be Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Wash., DC 4003 Wheeler Rd., SE ₽ Carrie B. Wynn / Sister Bes and of Health a it: If item 27 r other traum 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery Date 20a. Method of Disposition crematory or other place) Burial 2 XCremation 3 Removal from State Beltsville, Md. 4/24/09 Chesapeake Crematory Important: injury or off Offination 5 Other Specify 22. Name and Address of Facility permit. ture of Funeral S mice Licensee Capitol Mortuary 1425 Maryland Ave., NE Wash.,D Approximate Interval a not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart , or complications that caused the death, d Between Onset and Part I. Enter the diseas Physician failure. List only one cause on each line Death Medical Myocardial Fibrosis Immediate Cause (Final disease aminer Due to (or as a consequence of) or condition resulting in death) Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit sician/Medical AMENDED 23a,27 per me g891 5-1-09 vt tending physician a X UNPENDED The law requires that the death certificate be 23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: Day Year 3 Ectopic pregnancy 23b. Was decedent pregnant in the Fetal death Live birth past 12 months? Pregnant at time of death 5 Other (Specify) ned by the atte Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.0. Yes 2 No 3 Probably 4 ✔ Unknown ò 24b. Were autopsy findings available Completed 24a. Was an Records, has been prior to completion of cause of autopsy performed' death? No 1 V Yes 2 ✓ Yes 2 No page certificate | 26.Place of Death (Check only one) 25. Was case referred to medical Hospital or Attending Physician: director, Division of Vital Be Other₄ Residence 6 Hospital: 1 Nursing Home 5 examiner? DOA Inpatient 2 V ER/Outpatient 3 this 1 V Yes No ဥ 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury After 27. Manner of Death Certification: Yes 2 No 1 x Natural 5 Pending within 24 hours after death. To the Funeral Director: Director: Investigation 28f. Location (Street and Number or Rural Route Number, City 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) Could not be 3 Suicide determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier April 15, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Donna M. Vincenti, MD

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

OCME

31. Date filed (Month, Day, Year,

ORIGINAL

egistrar's Signatur

4			State of Maryland / Department of Health and N			009 327
1			State Registrar 1. Decedent's Name (First, Middle, Last)	2. Date of Dea	Reg. No	3. Time of Death
	Physici	an		APR I	Day	Year
	/Medio		Mary Christina Edge 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	J* * *	23	2009 /248997 hty of Death
	Examir	ner	1 2 - 1 0 - 2	1		
			Loriev A+ Be/ AIR Bel Air 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birt (Month, Da	<u>Harf</u>	9. Birthplace (State or Foreign
	Funeral Director		212-28-3755 1□ M 21 Yrs. Months Days Hours Min.	(Month, Da 12/4/1	y, <i>Year)</i> 927	Maryland
			Usual Residence of Decedent	12/4/1	721	
	yland now		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	a-fs	Director	Maryland Harford Bel Air			1 □Yes 2X No
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	th wi		1401 Bonnett Place Apt "K" 21015		U.S.	
	filed within 72 hours after death with the Maryland Hygiene. Other than "natural", or items 23a or 28a-f show ent, the Medical Evention metals another a	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (S	pecify Yes or No o Rican, etc.)		ace - American Indian, Iack, White, etc.
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V 8	ural"	D D	3 ☑ Widowed 4 □ Divorced Year or Dates: 15 Decedent's Education 16a. Decedent's Usual Occupation		16h Kind of	White Business/Industry
(U =	"nat	Completed	(Specify only highest grade completed) (Give kind of work done during most of work	king	TOD. KING OF	Business/industry
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a F	d be ental ked c	To B	Walter Smith Gibson Mary	Eliza	heth	Dressell
V = FDGE Maryland 21215-0036	2 should be filed within 72 hours aft and Mental Hygiens "natural", or surmatic event, the Medical Event, aurmatic event, the Medical Event	F	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Ru			
>\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	and 2 sealth a n 27 ls		Mary Sharon Edge (Daughter) 624 Harbour Oak Drive	Edgewo	od. Mar	cyland 21040
A A	s 1 and 2 should be filed within 72 hours after death with the Marylar if Health and Mental Hygiene. Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, Ite Medical Even interms 1 km notified at			Date		n - City or Town, State
MAR timore.	Pages nent of int: If ite		1X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Holly Hill Memorial Gard.	4/28	w: aala	Dirror Marriland
4	orta		21. Signature of Funeral Service Licensee 22. Name and Address of Facility	2009	MIGGLE	e River, Maryland
	permit. Pages 1 and 2 s Department of Health a Important: If item 27 is any injury or other tran		Ryzdzinski Funera 1407 Old Fastern A	l Home	PA Essex	Maryland 21221
			23a. Part 1. Enter the disease, or complication strat caused the death. Do not enter the mode of dying, such as cardiac	or respiratory a	rrest,	Approximate Interval Between
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	/Medical		disease or condition resulting in death) a. Deve to (or as a consequence of): /	_		
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9		Jed	IF FEMALE.			
Box	Attending Physician: The law requires that the death certific redeath. After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the pact 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy			Date of delivery
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	ires tha signed	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			ontribute to the cause of death?
D.	v requir been s should	ed	CHRONIC OBSTRUCTIVE LUNG DISEASE, A. FIB.	/ 10	Yes 2,2€1No	3 Probably 4 Unknown
ပိ	e 2 sh	ple l	CONGESTIVE HEART FAILURE, HYPERTENSION	24a. Was	an 24	b. Were autopsy findings available prior to completion of cause of
Division of Vital Records.	The I	ĕ	DIABETES MELLITUS CORONARY ARTERY DISEASE	perfo 1 □ Yes	rmed? 2 No	death? 1 □Yes 2 □No
i e	ian: The ertificate ctor, pag	Be	25. Was case referred to medical examiner?		/ \	
>	Physicia this cer al direct		1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☑ Nursing H	lome 5 ☐ Resi	dence 6 🗆 🤇	Other (Specify)
0	ding Pr h. After th funeral	Certification: To	27. Manner of Death ↑ Natural 5 □ Pending 28a. Date of Injury 28b. Time of Injury at Work?	28d. Describe		
<u>.</u>	Attendii death. ctor: A y the fu	äţi	2 Accident investigation M 1 Yes 2 No			1_1_1_1_1_1_1_1_1_1_1_1_1_1
<u>:5</u>	r Att	Ę	3 ☐ Suicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Could not be determined building, etc. (Specify)	28f. Location (Street and Nui vn, State)	mber or Rural Route Number,
Q	ital or irs afte ral Dire	Se				
	To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fu	cal	29a. Certifier (Check only (C			
	To the H within 2 To the F complet	Medical	one) and manner stated.		ood Data sin	and (Manth Day Vans)
	5 4 ki	-	29b. Signature and title of certifier 29c. License number			ned (Month, Day, Year)
			fullleager MD D45344		04/2	4/2009
, ,			30. Name and address of person w/ completed cause of death (Item 23a) (Type, Print)			15
10			31 Date filed (Month Day Year) 32 Penistrar's Signature	DE GRAC	E, M	0 21018
T	Sta Registi		30. Name and address of person wy completed cause of death (Item 23a) (Type, Print) SURESH DHANTANI MD 622 5 UNIONAYE, HAVRE 31. Date filed (Month, Day, Year) APR 2009 32. Pegistrar's Signature.			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 10:29 AM April 26. 2009 Anna Frederick /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Upper Chesapeake Medical Center Bel Air der 1 Year | If Under 24 Hrs. Harford Birthplace (State or Foreign Country) If Unde 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** Days Hours Min. Months 1 □ M 2**X**□ F 88 6/6/1920 Maryland Director 216-24-1196 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show of 2 should be filed within 72 hours after death with the Maryla thand Lental Hygene.

Ty is marked other than "natural", or items 23a or 28a-f show than mine the marked other than "natural", or items 23a or 28a-f show than mite event, he wide a fear in the marken mine. 1 ☐ Yes 2 X No Director Maryland Harford Bel Air 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2240 Quail Creek Court Funeral 21015 S. A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ▼No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. If Yes, Give Year or Dates: ≥ 3 Widowed 4 Divorced White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Owner Operator Bar 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ျ George Huber Elsie Classing 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21015 pe mit. Pages 1 and 2 Department of Health a Im. orant: If item 27 is an injury or other trai Linda Magdalyn Huber (Personal Rep.) Bel Air, Maryland 20c. Location - City or Town, State 2240 Quail Creek Court Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 4/27 2009 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Homo 1407 Old Eastern Avenue PA Essex, Maryland 21221 Lucha 23a. Part 1. Enter the disease, implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) BOWEZ Physician 8425 INFARCTION /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burial-tran and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ğ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No ↑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred To the Hospital or Attending P within 24 hours after death.

To the Funeral Director: After t completely filled in by the funera 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D3056296 4-27-2009 30. Name and audress of person who completed cause of death (Item 23a) (Type, Print) Chesapeake Dr. Bel Air, mo 21014 ason Birnbaum, m.D. 500 upper

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

0,0

Tredenck, Ruth Anne

frank.

32. Registrar's Signature

			_ For	Maryland / Depa	artment of H	lealth and M		ene	10070
		•	_ State Registrar	Ce	rtificate of	Death	Reg	. No. 2009	3 3273
	Dhuaiais		1. Decedent's Name (First, Middle, Last)				Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Marjorie Freggens				4 2		840 PM
	Examin		4a. Facility Name (If not institution, give street and nun			Location of Death		4c. County of Dea	
			FRANKLIN Square Hos	7. Age (In yrs. last birthday)		If Under 24 Hrs.	9. Date of Rieth		thplace (State or Foreign
	Funeral		1 □ M 2 /□ F	7. Age (In yrs. last birthday) 81 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Y 10/25/19	ear) Co	ountry) Jersey
	Director		145-22-4454 Usual Residence of Decedent	01			10/25/15	1101	, octoci
	yland now		10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits
	a-fsh	ctor	Maryland Baltimore	Middle Riv	<i>y</i> er				1 ☐ Yes 2 🔯 No
	or 28	Director	10e. Street and Number		10f. Zip Code		10g	. Citizen of What Co	ountry?
	be filed within 72 hours after death with the Maryland Hylgiene. d other than "natural", or items 23a or 28a-f show event, the haddel Evand her mast be notified at	rail	103 Day Coach Circle		21220			J. S. A.	
	tems	by Funeral	Armed For	dent Ever in U.S. 13. ces?	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
2	within 72 hours after iene. than "natural", or ite he Medical Exalidite	Ϋ́F	1 ☐ Never Married 2 ☒ Married 1 ☐ Yes If Yes, Giv 3 ☐ Widowed 4 ☐ Divorced Year or Da	e	1 □ Yes 2 🙀 No	Specify:		Specify:	w1 1 1
0000-0	hour tural		15. Decedent's Education		dent's Usual Occup	pation	16	b. Kind of Business	/hite /industry
2	in 72 n "na	bet	(Specify only highest grade completed)	(Give	kind of work done DO NOT use retired	during most of work			•
7	l with giene r tha	Completed	Elementary/Secondary (0-12) College (1	Homer	naker			Own Home	
2	othe othe	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, Ma	iden Surname)	
<u></u>	uld be Venta rked rlc ev	10 E	James Dunn			Margare	t Bor	quist	
Mai	and I		19a. Informant's Name/Relationship (Type. Print)	19b. Maili	ng Address (Street	and Number or Run	al Route Number, (City or Town, State,	Zip Code)
	permit. Pages 1 and 2 should be Department of Health and Menti Important: If Item 27 is marked any injury or other traumatic en once.		Robert Alfred Freggens (Husband) 10:	3 Day Coa	ch Circle	Middle	River, Ma	ryland 21220
ת מ	of He		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from 5	20b. Place of Dispo cemetery, cre-	osition (Name of matory or other plac	ce)		c. Location - City or	Town, State
	Pag ment ant: 1 ury o		4 □ Donation 5 □ Other (Specify)	Bayview (Crematory	26	27 09 Ba	ltimore (city, Marylan
Dallillo	permit. Depart Import any inj once.		21. Signature of Funeral Service Licensee	4	2. Name and Addre		H Da		
9	6 9 7 0 0		Muchael C. Jaffer			i Funeral astern Av	enue Ess	ex, Maryl	and 21221
Sc.	Physician /Medical		resulting in death)	nused the death. Do not en ich line.	ter the mode of dyi	ng, such as cardiac	or respiratory arres	t,	Approximate Interval Between Onset and Death
a Rei	Examiner	L	Sequentially list conditions, b.	×					
	sit sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause: (Ulsgase of injury)	or as a consequence of):					
	s executed an and rial-transit	xan	that initiated events	or as a consequence of):					
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	sath atter for u	Physician/Medica	in the past 12 months?	ant at time of death 5	☐ Ectopic pregnanc ☐ Other <i>(specify)</i> _	гу		23d. Date of de Month	elivery Day Year
ν. Γ	w requires that the de s been signed by the should be detached		Part II. Other significant conditions contributing to de	ath but not resulting in the u	ınderlying cause giv	en in Part I.	23e. Did toba	cco use contribute t	o the cause of death?
ž	quire an sig uld b	q pa	Cereprovascula A	certaits			1 ☐ Yes	2 No 3 F	robably 4 Unknown
שני	Attending Physician: The law re ard death. ector: After this certificate has bee by the funeral director, page 2 sho	Completed by	Autic value a	ilare.			24a. Was an autopsy performe	prior to death?	utopsy findings available completion of cause of
N I G	sian: ertific ctor,	Be (25. Was case referred to medical examiner?				h (Check only one)		
5	Physician: this certific ral director,	은		npatient 2 ER/Outpatie	nt 3 □ DOA Oth	ner: 4 🗆 Nursing Ho	me 5 Residen	ce 6 ☐ Other (Spe	ecify)
~	ing P	ü	27. Manner of Death 28a. Date 1 ✓ Natural 5 ☐ Pending (Monitorial)	of Injury 28b. Time of Injury Injury	Wor	Ŕ?	28d. Describe how	injury occurred	
2	Attending r death. ctor: After by the fune	cati	2 Accident investigation			Yes 2□No			
	or At fter d Sirect in by	Certification:	determined 286. Place	of Injury - At home, farm, st ng, etc. <i>(Specify)</i>	reet, factory, office		City or Town,		iural Route Number,
7	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical Ce	29a. Certifier 1 Certifying Physician: To the (Check only one) Medical Examiner: On the band man	best of my knowledge, dea asis of examination and/or interstated.	th occurred at the ti nvestigation, in my	ime, date and place, opinion, death occur	and due to the car red at the time, dat	use(s) and manner a e and place, and du	as stated. e to the cause(s)
	To the within To the comple	Me	29b. Signature and title of confife		29c. Licens	se number	290	d. Date signed (Mon	th, Day, Year)
	->-0		1 Com		DE	4721		4/24/2	
•			30. Name and address of person who completed caus	e of death (Item 23a) (Type	Print)	1 1 36		117	
			DR KAMLUN R AYYEND	- 9000 F	RANKLIN	Squar	e DR B	Salto M	id 21237
	Sta	ite	31. Date filed (Month, Day, Year)	egistrar's Signature	and I				
	Registr		APR 27 ZUOY A	e of death (Item 23a) (Type, 9000 F	1000				
51.16	JH 17 Rev 1/2	004							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #8 per Fh 9891 5/6/09 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 0:30AM 009 /Medical County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 8. Date of Birth 2/22/1936 irthplace (State or Foreign Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 6. Sex **Funeral** Days Months Hours Min. 1□M 2**X**F Orangeburg, SC. 3 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 Yes 2 No Completed by Funeral Director 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry
HOLY CROSS 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 74 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ 19a Informant's Name/Relationship (Type. Print) or Rural Route Number, City or Town, State, Zip Code) 1,MD-20707 20b. Place of Disposition (Name of cemetery, crematory or other 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) andover, MD. 420 H STIGET NE. 21. Signature of Funeral Service Licenses HENRY FUNERAL HOME enry M01178 WGSH, DC. ZOCOZ Part1. Ent. Tim disease, or complications thin caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause of each line. Immediate Cause (Final Physician EPSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Orecta Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) __ in the past 12 months? Month Day Year 2 No After this certificate has been signed by funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Bother Specify, Home 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 3☐ Suicide 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29d. Datersigned (Month 30. Name and address of person who completed cause of death (Item 28a) (Type, Print) 7500 Greenbelt, MD. 20770 Tar Kway 101A State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Garibay 4-2009 anez 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death TSVILL HOME HYQT Hear If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days Hours Min. 461-64-498 Months 1 M 2 □ F 8 MEXICO Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Washington, 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number SA 20010 KENYON STREET 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: MEXICAN Specify: M 1 des 2 No EXICA 3 ☐ Widowed 4 ☑ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SINESS Ontractor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) emedio 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) GARIBON ST., N.W., Wash, DC AleTHORPE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Gate Of Heaven Silver Spring, MD. 1 ■ Burial 2 □ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee B.K. Henry Funeral Nome WasH., D.C. 20002 QMux M01178 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 3 weeks neumonia Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown

Physician /Medical Examiner Examiner The law requires that the death certificate be executed and

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show edical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after o Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner once.

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

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death v

burial-tran physician the for use detached by signed t funeral director, page 2 should certificate Atter this within 24 hours after death. To the Funeral Director;

Physician/Medical

Be Completed by

Certification: To

Medical

Division or Vital Records, P.O. Box 68760,

or Attending Physician:

Hospital

9 LI OTIKITOWIT		
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown
		24a. Was an autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ∰ No 1 ☐ Yes 2 ☐ No
25. Was case referred to medical	26. Place of Death	Check onlone
examiner? 1 ☐ Yes 2 至 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho	me 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1 ■ Natural 5 □ Pending 2 □ Accident investigation	(Month, Day Year) Injury Work?	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		28f. Location (Street and Number or Rural Route Number, City or Town, State)
	Physician: To the best of my knowledge, death occurred at the time, date and place, aminer: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	

29c. License number

State Registrar

filled in by

29b. Signature and title of certifier

findres

Ligon -ar Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

50/02

29d. Date signed (Month, Day, Year)

D51051 April 20, 2009 Rd, Elliatt City, MD 21042

chael Gu	zik		- For State Registrar	Sta	te of Marylan			of Healt of Death		/lental H	R	leg. No.	20		132
Phy edical Ex	ysicia xamir	ner	1. Decedent's Name Micha	el	С.		zik	145 Oin. T		ation of Deat	2. Date of Dea Month April 19, 2	Day 2009	Year	3. Time o 0956	
					, give street and numb Medical Center	oer)			Burnie			1	Anne Arunde	el	
Fund Direct		- 1	5. Social Security No. 218–83–8423		5. Sex 7.	Age (In yrs. la		If Under		F Under 24Hr Hours Min	s. 8. Date of Bi		Fore		
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/land	8a-f show at once.	ē	Maryland	Anne A	rundel	Pasad	ena	10f. Zip	Cada			10a Cit	izen of What Co		es 2 X No
he Mar	3a or 28a-f sho	Oirec	10e. Street and Nun 729 Bridge					2112				•	S.A.	ontry :	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.	ems 23a t be not	Funeral Director	11. Marital Status 1 X Never Marrie		12. Was Deced						Specify Yes or No o Rican, etc.)	0-	14. Race - Ame White, etc.	erican Indiar	n, Black,
ter deat	or its		3 Widowed		1 Yes	2X No		Yes 2					Specify: [
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36 iin 72 h	han "n dical Ex	Completed	Elementary/Secon N/A	ndary (0-12)	College (1-4 N/A		dumi	Deper	_	NOT use to	alled)	1	N/A		
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Baltimore, permit. Pages I ar Department of Hee	lant: J		4 Donation 5	Other Spe	ecify:		y Cross	s Cemete	ery		23/09		oklyn Pai	rk, Mar	yland
Balt permit. Depart	Impor		21. Signature of Fur	neral Service L	Licensee		1	Name and COLLLY-	Polynia	Facility ak Funet Road Par	ral Home, sadena, M	P.A.	and 21122		
Physic	cian	\dashv	23a. Part I. Enter the failure. List onl	e disease, or c	complications that cause	sed the death.	Do not ente	er the mode of	of dying, suc	h as cardiac	or respiratory a	rest, sh	ock, or heart		imate Interva
Med kam	_		Immediate Cause (for condition resulting	Final disease	a. Sudden Due to (or as a co			deatl	n in	infan	cy (SUD	(1			Death
		<u>.</u>	Sequentially list cor if any, leading to im	nditions,	b Due to (or as a co	onsequence of):								
		Examine	cause. Enter Under (Disease or injury the	rlying Cause hat initiated	c. Due to (or as a co										
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0, e be exec	sician and burial - transit	edical	X UNPENDED		AMENDED	23a,27,	,28a-i	,perMl	E, g89	93 7/1	/09 TT				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.		n/Me	IF FEMALE: 23b. Was decedent			tcome of pregr	nancy	Fetal death	3	Ectopic preg	nancy	2	3d. Date of deliv Month	ery Day	Year
ox 6 ath cer	attendi or use	Physician/M	past 12 months	i? No 9 ☐ Unkr	2011/2	nt at time of de	ath 5	Other (Spe	cify)						
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of V	After th	일	27. Manner of Deat	2 No	28a. Date of	Injury	28b. Time		28c. Injury a	it Work?	28d. Describe	e how in	njury occurred		·
sion ttendii death.	y the fi	atio	1 Natural 2 Accident	5 Pendi Invest	ing tigation Fd 4/	19/09		17 am		2X No	unk			2 .5 .	N O
Division of Vital Records, P.O. Box 6876 real or Attending Physician: The law requires that the death certificat is after death.		Certification:	3 Suicide	6 X Could determ	I not be mined (Specify)	of Injury - At ho	ome, farm, s ceside	street, factory ence	, office build	ding, etc.	Pasad	(Street State) ena	and Number or 729 Bri MD	dge D	r r
Hospit 24 hour	Finner tely fill		4 Homicide 29a. Certifier (Check only	Certifying Ph	vsician: To the best	of my knowleds	ge, death o	ccurred at the	e time, date	and place, a	nd due to the ca	use(s) a	and manner as s	tated.	
Divis To the Hospital or A	To the Funeral completely filled	Medical	one) 2 🗸		niner:On the basis of and manner sta	examination at ted.	nd/or invest				d at the time, dat				
		Σ	29b. Signature and	aitle of certifier	1/ mi	7		29	O.C.M.				i. Date signed <i>(i</i> oril 20, 2009	worth, Day,	rear)
~		}	30. Name and addr.	ess of person	who completed cause	of death (Item	23a)								
D	1		Melissa Bra		Assistant Medi			1 Penn St	reet, Bal	timore, M	D 21201				
R	St Regist	ate	31. Date filed (Mont	th, Day, Year) D 2 7 3		istrar's Signatu	ire								
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DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 🛛 🗍 🦠 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** DODMAN М DAVID /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Randallstown
Under 1 Year I If Under 24 Hrs Northwest Hospital 8. Date of Birth (Month, Day, Year) Birthptace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Months Hours **X**□ M 2□ F MD Director 55 218-60-9320 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ir than "natural", or Itama 23a or 28a-f ahow the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Owings Mills MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 221 Ritterslea Court

11. Marital Status
1 Never Married Married
3 Widowed 4 Divorced

15. Decedent's Education
(Specify only highest grade complete
Elementary/Secondary (0-12)
College
12th grade
3 Y:

17. Father's Name (First, Middle, Last) 21117 U.S.A. Pages 1 and 2 should be filed within 72 hours after death and Mental Hygiene.
ant: If item 27 Is marked other than "natural; or Itame 23, ury or other fraumatic avent, the Medical Exemples must by or other fraumatic avent, the Medical Exemples must Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Tes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 No Specify: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Golden Touch College (1-4or 5+) Cleaning Services 3yrs Owner 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Claudine Young Charles Goodman ္ရ 19a. Informant's Name/Relationship (Type, Print) Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 221 Ritterslea Court, Owings Mills, Md 21117 Helena Poindexter-Goodman 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Depertment of Importent: If any Injury or once. Metro Crematory Inc 4/22/09 Baltimore, Md 4 Donation 2.7. Signature of Funeral Service Licenspe March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immeriate Cause (Final Due to (or as a consequence of): Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine ng physicien and as the burial-transit The law requires that the death certificate be executed NOST resulting in death) Last Due to (or as a consequence of): Box 68760. JLABE Physician/Medical MELLITUS anding l IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) P.O. I ned by the e e detached f 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. signt be c δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No certificele 1 🗌 Yes 3 No or Attanding Physician: director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) After thi 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 2 Accident 5 Pending death. within 24 hours after death.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No М investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 241430 N. W. HOSP RANDALLSTOWN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DBAZEE EDWARD

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

2009

barle

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 2009-13278

Amend #5 per FH G890 4/27/09 TT

State of Maryland / Department of Health and Mental Hygiene 1000 10070 1 - For State Registrar Certificate of Death Date of Dea 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Onore ih /Medical . Facility Name (If not institution, give street and number, Examiner BALTIMORE ENVOY OF PIKESVILLE BALTIMORE 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs 8. Date of Birth JAN 26 ay, 1915 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours NEWTYORK 1 ☐ M 2 😿 F **866**-03-0859 94 Director Usual Residence of Decedent 10a. State MD 10d. Inside City Limits Ob. County BALTIMORE 10c. City, Town or Location BALTIMORE death with the Marylan permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be cuttled at once. 1 ☐ Yes 2 🔀 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21208 8511 SNOWREATH ROAD Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. . Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 [Y] No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 X No Specify: Specify: WHITE Be Completed by 3 X Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) BARBANELL BIRDIE MESTER **ABRAHAM** ၉ 19a. Informant's Name/Relationship (Type. Print)
MARSHALL GOLLANCE/SON 19b Mailing Address *(Street and Number of Fural Poute Number, City of Town Side Pip Code)* 8511 SNOWREATH ROAD BALTIMORE, MARYLAND 21208 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State MONTEFIORE CEMETERY 4/26/2009 ST. ALBANS, NEW YORK 4 □ Donation 5 □ Other (Specify) 22. Name and Address of FaciligoL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licens 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on Jach line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit and Due to (or as a consequence of) ned by the attending physician detached for use as the burial Division of Vital Records, P.O. Box 68760 Be Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Month Year 5 Other (specify) 1∐Yes 2∐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 □ Yes 2 certificate within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, I 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes Medical Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 29a. Certifier 🔂 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number of death (Item 23a) (Type, Print) Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

APR 27

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

		1	For State Registrar	State of Ma	•	epartment of r Certificate of			g. No. 200)9 13279
	Physicia		1. Decedent's Name <i>(First, Middle, Last)</i> Matilda	Н.	Hoffman		2.	Date of Death Month	Day 20	ar al. 037 M
	/Medica	_	4a. Facility Name (If not institution, give s			4b. City, Town, o	r Location of Death	1. 1.	4c. County of D	
	Funeral Director		5. Social Security Number 6. Sex	Y 7. Age	(In yrs. last birti		If Under 24 Hrs. 8. Hours Min.	Date of Birth (Month, Day, ug. 20,		Birthplace (State or Foreign Country) Maryland
Aaryland	f show	JO.	Usual Residence of Decedent 10a. State 10b. County Maryland Baltimore		10c. City, Town					10d. Inside City Limits 1 ☐ Yes 2 ∑ No
n with the P	3a or 28a- st be notif	Funeral Director	10e. Street and Number 2851 Louisanna Avenue			10f. Zip Code 21227		10	0g. Citizen of What U.S.A.	Country?
5-0036 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Important: or items 23a or 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 []Yes 24 N If Yes, Give Year or Dates:	lo	1 □Yes 2 No			Black, W Specify:	American Indian, /hite, etc. White
1215-0 /ithin 72 ho	ne. han "natul e Medical	Completed by	15. Decedent's Edu (Specify only highest grade	cation e completed) College (1-4or 5- N/A		Decedent's Usual Occu (Give kind of work done life. DO NOT use retire Production Clo	during most of working		16b. Kind of Busine McCornick	
Maryland 21215-0036	ental Hygie ked other t ic event, III	To Be Co	17. Father's Name (First, Middle, Last) Gustav		icolowski		18. Mother's Name (I	First, Middle, N		ohnson
Mary Ind 2 should	alth and M 27 is mar er traumat	-	19a. Informant's Name/Relationship (Ty-Robert L. Hoffman (Son		82	Mailing Address (Stree 218 West End D	rive Orchard I	Beach Mar	cyland 2122	6
Baltimore,	ment of He ant: If item ury or othe		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	Removal from State		Disposition (Name of y, crematory or other pla even Mem. Pk.	04/24/09	9 _ (20c. Location - City Glen Burnie	
Balt permit.	Departi Importi any inj once.		21. Signature of Funeral Service Licens	de		22. Name and Addr McCully—Poly 3204 Mountai	ess of Facility niak Funeral I n Road Pasader	Home, P.A na, Mary	A. Land 21122	Approximate
	ysician		23a. Part I Inter the disease, or complishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. ANOX	IC EN	CEPHALOPA	THY	respiratory arr	est,	Approximate Interval Between Onset and Death OAYS
	Medical caminer	ī.		b	a consequence of					
68760, ificate be executed	ng physician and as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as	a consequence	of):				
		Medical	IF FEMALE:	d				/i		
COLDS, P.O. Box requires that the death cen	y the attending ched for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death	3 ☐ Ectopic pregnar 5 ☐ Other (specify)	ncy		23d. Date o Month	
MATILDA Records, P.C	s been signed by the should be detached	ed by Pr	Part II. Other significant conditions co		ut not resulting in	n the underlying cause g	iven in Part I.		bacco use contribu	te to the cause of death? Probably 4 Unknown
M A I Rec	ate has t	Completed by	ALZEIMER'S D. HYPERLIPIDEMIA					24a. Was a autops perfore 1 □ Yes	sy prio negi? dea	re autopsy findings available ir to completion of cause of th? Yes 2 No
l√ f Vita ysician:	h. : After this certifics : funeral director, p	æ	25. Was case referred to medical	Hoenital:	ent 2 ☐ ER/Ou	utpatient 3 □ DOA	26. Place of Death (ther: 4 Nursing Hom-		ne) ence 6 □Other	(Specify)
十0下FMAN / Division of Vital	ath. nr: After th	ation: T	27. Manner of Death Natural 5 Pending Accident investigation	28a. Date of Inju (Month, Da	iry 28b. 7 y, Year)		ork? □Yes 2□No		ow injury occurred	
HOFPITAL DIVIS		Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	building, et	c. (Specify)	rm, street, factory, office		City or Tow	n, State)	or Rural Route Number,
To the Hospi	thin 24 hou the Fune mpletely fil	Medical	(Check only 🙎 Medical Exam	ysician: To the best iner: On the basis of and manner st	of examination ar	e, death occurred at the nd/or investigation, in my	time, date and place, at opinion, death occurre	d at the time, o	cause(s) and mann date and place, and 	due to the cause(s)
٩	to to	_	29b. Signature and title of certifier	. M.		P21;	198			19 2009
7	101		30. Name and address of person who of BHAVANDEEP 31. Date filed (Month, Day, Year)	BATAT	leath (Item 23a) rar's Signature	(Type, Print) 900 BA	CATON A	ND 2	1229	
	Sta Registi		ADD 0.7 2000	A P	A					

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **HOBBS** JR. GUY A. 4c. County of Death City, Town, or Location of Death Baltimore N/A tal If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign 8. Date of Birth Nov. Dev. 7. Age In yrs. last birthday Days Yea[1939 Hours Min. Mary Land 1**2** M 2□ F 69 218-36-8109 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 MYes 2 □ No Maryland Baltimore N/A 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number U.S.A. 21201 Apt 101 1 West Conway Street 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Nes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married White 1 □Yes 2 No Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) A & P Stores Warehouseman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Smith Gladvs Guy A. Hobbs 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type. Print) 1 West Conway Street Apt 912, Baltimore, Maryland 21201 Elizabeth Gray 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 M Cremation 3 ☐ Removal from State Bayview Crematory 04 - 23 - 09Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 130 Fast Fort Avenue, Baltimore, Maryland 21230 11 Approximate Interval Between Onset and Death 23a. P911. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Immediate Cause (Final sease or condition resulting in death) ue to (or as equince of): Urinary Truet Infection Selbridge Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Die to (or as a consequence of Crary IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) □Yes 2□No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 2 5100 1 ☐ Yes 25. Was case referred to medical examiner?
1 ✓ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c, Injury at Work? 1 Natural 5 Pending investigation 1 □Yes 2 □No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier

Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760, P.0. Records, Division of Vital

burial-tra attending physician use as the ģ the pe page 2 should certificate director, this After this within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Physician /Medical

Examiner

Funeral

Director

or items 23a or 28a-f show

Director

Funeral

2

Completed

Be

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Examine

Physician/Medical

2

Completed

Be

Certification: To

Medical

(Check only

29b. Signature

30. Name and

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ira Medical Examinar must be notified at

Physician

/Medical

Examiner

and

Mary

3altimore,

after death with the Maryland

State Registrar

31. Date filed (Month, Day, 32

Degistrar's Signature

and manner stated.

address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

0066268

Greneral

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 0420 AM APRIL **Physician** HODGE 22 2009 SHANIKA /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Nov . 10 , 1979 7. Age (In yrs. last birthday) 5. Social Security Number Md -Days **Funeral** 1 🗆 M 2 🔀 29 219-94-2630 **Director** Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland eath and Mental Hygiene.

n. 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County 1 Yes 2 No Director Baltimore Parkville MD 10g, Citizen of What Country? 10f, Zip-Code 10e. Street and Number 21234 USA 1225 Dalton Rd Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give X Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: ò black 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) injury or other traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4 or 5+) Medical Records Assistant Sinai Hospital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Priscilla McCown Leonard Hodge 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Important: if item 27 is any injury or other traum Parkville, Md. 21234 1225 Dalton Rd Leonard Hodge (father) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Burial 2 Cremation 3 Removal from State Apr. 29,2009 Baltimore,Md. Denation 5 Other (Specify) Oak Lawn Cem 22. Name and Address of Facility Calvin B. Scruggs Funeral Home me of Funeral Service Licensee 3a. Part 1. Enter the disease, or complications that caused the learn shock, or heart failure. List only one cause on each line. 1412 F. Preston St. Palto, Md. 21213 Approximate Interval Between Do not enter the mode of dying, such as cardiac or respiratory arrest Onset and Death HEMOPPHAGE INTRACRAMIAL Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence of attending physician and d for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months?
1 ☐ Yes 2 🛣 No 5 Other (specify) 4 Pregnant at time of death signed by the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? RENAL DISEASE 24a. Was an 20-5TAGE certificate has 2 🗌 No 1 Yes Yes 26. Place of Death (Check only one) 25. Was case referred to medical or Attending Physician: Be examiner? Hospital: 12 Inpatient Other: 4 \sum Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA ၉ 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 1 X Natural 5 Pending investigation 1 Yes 2 No death. 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) City or Town, State) 4 Homicide the Hospital 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 22 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only one) 29c. License number

RES - 000 29d. Date signed (Month, Day, Year) 29b. Signature and title of con 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 LAKK R. EMNGER M.D. 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month irginia A. Jordan 1225 PM April 2009 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Anne Arundel Annapolis 1074 Little Magothy View 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day Year) May 2, 1939 Social Security Number 7. Age (In yrs. last birthday) Days Min. Mary Land 1 □ M 2 🕅 F 219-26-4643 69 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 □Yes 2 No Maryland Anne Arundel Annapolis 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21409 1074 Little Magothy View Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No Specify Specify. 3 → Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Restaurant Waitress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mills. Μ. Allen Virginia E. Joseph 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 999 Deep Creek Avenue Arnold Maryland 21012 Lisa Litts (Daughter) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 04/23/09 Glen Haven Mem. Pk. Glen Burnie, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee McCurly-Polyniak runeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) yes, outcome of pregnancy
Live birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 3 🗌 Ectopic pregnancy Month 5 Other (specify) 2 MNo 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 × No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Renal Insufficiency 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed HUPERTENSIO, 2 No 1 ☐ Yes 1 □Yes 2 XNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation

Examiner Hospital or Attending Physician: The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Division of Vital Records, P.O. Box 68760, certificate 24 hours after death.

Funeral Director: After this certific letely filled in by the funeral director,

Physician /Medical

Physician

/Medical

Examiner

Director

Funeral

2

Completed

Be

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show amy Injury or other traumatic event, the Midfall Evantine could be notified at once.

Baltimore, Maryland 21215-0036

Examiner Physician/Medical Completed by Be Certification: To

23b. Was decedent pregnant in the past 12 months?

2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

Sensield Rd, Site 8, Severnalady MD

1 □Yes 2 □No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

6 ☐ Could not be

determined

29c. License number

29d. Date signed (Month, Day, Year) 4-21-09

State Registrar

Medical

31. Date filed (Month, Day, Year)

within 24 hor To the Fune completely f

the

			1 - For Amend #30 per DVR g890 4/2/	/09 T1 Cer	rtment of F tificate of I	lealth and M D <i>eath</i>	lental Hygid Reg	ene j. No. 2009	13283
	Physicia	an	1. Decedent's Name (First, Middle, Last)	-			Date of Death Month	Day Year	3. Time of Death
* *	/Medic Examin	al	Kobert F James 4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	April	16 2009 4c. County of Death	
1	Examini	CI	Northwest Hospital		Randa	11stowal	MI)	BaltiM	
	Funeral Director		5. Social Security Number 6. Sex 1 7. Age (In yrs. las 119–32–9701 1 7. Age (In yrs. las 72 72 72 72 72 72 72 72 72 72 72 72 72	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) 1–12–1937	(ear) 9. Birth	place (State or Foreign intry) MD
	D		Usual Residence of Decedent	T			No 3200 20.00		10d. Inside City Limits
	// Aarylar f show	or	10a. State 10b. County 10c. City,	Town or Loc	Baltimore				1 Yes 2 No
	r 28a-	Director	10e. Street and Number		10f. Zip Code		100	g. Citizen of What Cou	intry?
	23a o	ralD	3801 Bartwood Road			1215		USA	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, it is Medical Examinational be notified at once.	by Funeral I	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		Vas Decedent of H iYes, specify Cuba □Yes 2MNo	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify: Aft	
2-0	72 hou natura fical E	eted	15. Decedent's Education (Specify only highest grade completed)		ent's Usual Occup	ation during most of work		6b. Kind of Business/Ir	ndustry
Baltimore, Maryland 21215-0036	within ene.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	life. D	nter))		Printing Co.	
d 2	e filed of Hygin other vent, I	Be Cc	17. Father's Name (First, Middle, Last)	11.0	THE SECOND	18. Mother's Name	e (First, Middle, Ma		
ylar	ould be I Menta larked	To E	Albert James			Beatrice			
Mar	d 2 sh Ith and Ith and 27 Is m traum		19a. Informant's Name/Relationship (<i>Type. Print</i>) Wendy Johnson/Daughter			and Number or Run Road, Balti		City or Town, State, Zi 아마	ip Code)
re,	ss 1 an of Hea item 2		20a. Method of Disposition 20b. Pla		sition (Name of patory or other place			Oc. Location - City or T	own, State
E E	Page tment tant: If		11 11 Burial 2 Li Cremation 3 Li Removal from State 1	g Memor	ial Park	4-22		Woodlawn, MD	
Bail	permit Depar Impor any In	~	France N. Wylw	9	200 Liberty	yRoad, Randa	allstown, M		
and a	Physician		23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a	Do not ente	er the mode of dying	ru	or respiratory arres	st,	Approximate Interval Between Onset and Death
×	/Medical Examiner		Due to (or as a conseque	ence of):	Paulo	reat his			~ 2 dals
	70 .t=	ner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying	once of):	g runz	ree is			~ 449
	ficate be executed physician and s the burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the cons	ence of):					
8760,	re be e /sician e buria	dical E	d.						
	ertificating physe as the	Medi	IF FEMALE:	-0.					
O. Box	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnant 1 □ Live birth 2 □ Fetal of 4 □ Pregnant at time of dec	death 3□	Ectopic pregnanc Other (specify) _	у		23d. Date of deli	very Day Year
ر. ح.	gned by		Part II. Other significant conditions contributing to death but not result	ting in the un	nderlying cause giv	en in Part I.	23e. Did toba	acco use contribute to	
org	require een sig	ted l	Cordine tryist. Kespiratury de	arleire	-, coup	<u>naloparnij</u>	,	2 □ No 3 □ Pro	obably 4 🗗 Unknown
	r: The law ficate has b r, page 2 sf	Completed by	Corounn arten disease Lactic	, Sh tero	,	<u>agulopat</u> n		prior to c death? 1 □ Yes	topsy findings available ompletion of cause of
Z.	Physiclan: r this certific ral director,	o Be	25. Was case re rred to medio examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatien	t 3 □ DOA Oth	er.	h <i>(Check only one)</i> ome 5□ Residen	ice 6 Other (Spec	eify)
n of	ng Ph Vfter th	on:T		28b. Time of Injury	Wor	y at k?	28d. Describe how		
Divisio	To the Hospital or Attending Physician: The law requires that the di- within 24 hours alier death. To the Funeral Director After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	Certification: To	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At hombuilding, etc. (Specify)	ne, farm, stre		Yes 2 □ No	28f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
_	Hospital Hospital Funeral tely filled	Medical Ce	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my know 2 Medical Examiner: On the basis of examinatic and manner stated.	/ledge, death on and/or inv	n occurred at the ti vestigation, in my o	me, date and place opinion, death occur	, and due to the car rred at the time, dat	use(s) and manner as te and place, and due	stated. to the cause(s)
	To the within 3	Mec	29b. Signature and title of certifier		29c. Licens		29	d. Date signed (Month	n, Day, Year)
			> Thun 1.0.		HOO	68505	, c	APR 16/2	2004
			30. Name and address of Jers in who completed cause of death (Item 3		Print) (Istoudal	111).	Tisha K	. Fujii	į.
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signatu		. 4. 1				
	3,130		AFR Z (//RM //www /	7. ABA	W. See				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #9 per Fh 9890 4.29.09 TT

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2041 **Physician** 2015 45 PM Jackson Jean Gloria /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Season's Hospice Randallstown If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign MD Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1□ M **%**□ F Yrs. 214-50-5993 60 Director 09 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Expriner must be notified at once. 1√Yes 2□No Director NA Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. Funeral 21244 3206 Greenmead Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Specify: ģ 3 Widowed 4 Divorced Black Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore City College (1-4or 5+)
4yrs+ Elementary/Secondary (0-12) Teacher 12th grade School System 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lottie Henry William E. Williams 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3206 Greenmead Road, Baltimore, Md 21244 <u>Phillip Jackson-Husba</u>nd 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 4/27/09 Woodlawn, 22. Name and Address of Facility
March F/H West 21. Signature of Funeral Service Ligenses 21215 4300 Wabash Ave, Baltimore, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Carcinomatosis revitorical /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical attending pl IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) ned by the a 1 ☐ Yes 2 No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? within 24 burns after death.

To the Funeral Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be or Completed by 1 Yes 2 No 3 Probably 4 Unknown Cancer 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 A No 2 No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 🔀 Natural 1 □Yes 2 □ No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mpleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who co-1th Nonue Suite 203 31. Date filed (Month, Day, Year) 2. Registrar's Sign State APR 27 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 3:10 AM **Physician** 2009 Kraemer /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A ALTIMORE HOSPITAL AGNE f Under 1 Year | If Under 24 Hrs 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Sex 1□M 2 F Months Hours Sept. 18, Virginia 74 228-40-0001 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any hipury or other traumatic event. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 Yes 2 □ No Funeral Director N/A Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21223 1727 Wilkins Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Specify: Completed by White 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Tavern Bartender 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Morris Gladys William P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1727 Wilkins Avenue Baltimore, Maryland 21223 Charles Wayne Hyatt (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 04/28/09 Marriottsville, Maryland Crestlawn Mem. Grdns 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee ²MCC11y-Folyniak Funeral Home, P.A. 237 Fast Patapsco Avenue Baltimore, Maryland 21225 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shocked heart failure. List only one cause on each line. SHOCK Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner INFECTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner death certificate be executed PNEMONIA burial-trai resulting in death) Last Due to (or as a consequence of): inding physician ause as the burial-P.O. Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No atter for u 1 Live birth 2 Precaised 4 Pregnant at time of death 9 Unknown 3 Ectopic pregnancy Month Year 5 Other (specify) ned by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? KREMER (DA ivision of Vital Records, HYDERTENSIEN 1 Yes 2 No 3 Probably 4 Unknown DIABETES MELLITHS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performe ARTERY CORONARY 2 No this certificate 1 ☐ Yes 2 No 1 🗌 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Medical Certification: To funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 2 Accident To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director; After th completely filled in by the funeral 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certific D43378 900 CATON AVE, BALTIMORE, MD ST. AGNES HOSPITAL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BHAVANDEEP 31. Date filed (Month, Day, Year) Registrar's Signatu State Registrar

Registrar

			State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1328							3287	
П	Physici	an	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month Day Year 3. Time of Death				
	/Medi		Rose Theresa Logue				April 23 2009 8:20A M				
	Examir	ier	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death								
	Funeral		Seasons Hospice 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		Randallstown If Under 1 Year If Under 24 Hrs.		8. Date of Birth		Baltimore 9. Birthplace (State or Foreign		
	Director		215-28-9874 1 M 2XF	85 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day,	Year) 1923	Country) Marylan	-	
21215-0036	put N	Director	Usual Residence of Decedent								
	f shored		100 Marie Carlo								
	the N 28a- notifi		Maryland Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States								
	h with 23a ou st be	a D	106 Rockrimmon Road 21136			5		nited f Amer			
	72 hours after death with the Maryland natural", or items 23a or 28a-f show Iteal Examiner must be notified at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Dec			Decedent of Hispanic Origin? (Specify Yes or No- , specify Cuban, Mexican, Puerto Rican, etc.)			14. Race - American Indian,		
		by Ft	1 Never Married Married 1 Yes XXNo	1 □Yes XXX No Specify:			ilcari, etc.)		Black, White, etc. Specify: Table 1 + 0		
	hours tural	ed b	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	160 Door	16a. Decedent's Usual Occupation			Specity: White 16b. Kind of Business/Industry			
	nin 72 In "na	plet	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	kind of work done durii DO NOT use retired)		g '	ob. Killa of Bi	isiness/industry		
21	d with	Completed	12th Homemaker					Own	wn Home		
pu	be file ital Hy d oth event	To Be (17. Father's Name (First, Middle, Last)		18	3. Mother's Name	(First, Middle, M	aiden Surnam	re)		
Z a	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If time Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Marten Examiner must be notified at once.		Samuel Marzullo Rose Tamburo								
ăa			19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 106 Rockrimmon Road, Reisterstown, MD 21136								
Baltimore, Maryland	s 1 ar of Hea item		20a. Method of Disposition		sition (Name of natory or other place)	Da	ite 2		City or Town, S		
	Page nent c ant: If ary or		Page dia E - Cisabilon o - Tremoval nom State	_	Mem'1 Park	Apr. 2009		Sykesyf	1730 Ma	ruland	
alti	epartr epartr ports y inju		Sykesville, Palyiallo								
	80 E 8 9		21. Sometime of Fund 1 State of Fundament of								
	Physician /Medical Examiner		23a Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Sock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death disease or condition a. A To the Approximate Interval Between Onset and Death Onset and De							val Between	
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	incate be executed g physician and is the burial-transit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):								
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×	leath certifi attending for use as		IF FEMALE: 23b. Was decedent prognet. 23c. If yes, outcome of pregnancy					23d Dat	20d Date of delivery		
. Box	death e atte	icial	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No ☐ Pregnant at time of death ☐ Use of the pregnancy ☐ Use of the pregna					23d. Date of delivery Month Day Year		Year	
Division of Vital Records, P.O. Box	w requires that the dispersion signed by the should be detached	by Physician/M	9 ☐ Unknown								
	res th		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death?			
	requi	sted					1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown				
	e law has l	Completed					24a. Was an autopsy		Vere autopsy fin prior to completic	ndings available on of cause of	
		Certification: To Be Co	25. Was case referred to medical					performed? death? 1 □ Yes 2 ™ No 1 □ Yes 2 □ No			
	Ni ibi		25. Was case Telefred to medical examiner? 1 Yes 2 No								
			27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred								
<u> </u>			1 Natural 5 Pending (Month, Day, Year) Injury Work? 2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be 288 Bloom of Leiture At home from short factors of the state of the stat								
Ë		Ě	4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)						e Number,		
_	spital ours s eral I	Medical Ce	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
)	n 24 h		(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
	Vithir Comp		29b. Signature and title of certifier 29c. License number					29d. Date signed (Month, Day, Year)			
			Newas & Bentin H			45931 A			pril 23 2009		
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Debarah I Burton 2835 Smith Avo Suite 203 Baltimoro MD 21209								
F	Stat						5 000				
	Registra	ır	APR 27 2009 Centura	Signature San	Ked						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Pak **Physician** 00 2609 23 /Medical 4b. City, Town, pr Location of Death acility Name (If not institution, give street and number) 4c. County of Death Examiner niversity of Maryland Medical timore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign Country) unk 6. Sex 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Hours Min. Months Days 1 M 2 □ F 213-30-4586 Director 04/02/1935 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is five items to not the content once. 1⊠Yes 2 □ No Directo MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21201 USA Funeral 501 W. Franklin St. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🐴 No 14. Bace - American Indian. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk Unk Unk 18. Mother's Name (First, Middle, Maiden Surname) u n k 17. Father's Name (First, Middle, Last) unk Be ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Cassandra Lucas/ Guardian 10 N. Calvert St.Balto, Mp. 21201

se of Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Zion Cemetery 04/24/09 Lansdowne, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wylie Funeral Home P.A. 21. Signature of Funeral Service Licensee 638 N, Gilmor St. Balto., MD, 21217 reune. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final neumonia Physician disease or condition resulting in death) /Medical Die to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate caue. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed ned by the attending physician and detached for use as the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy Month 5 Other (specify) 1 □Yes 2 □ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying pause given in Part I. 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 🗌 No icate has been si ; page 2 should t 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe 2 1 No After this certificate 2 No 1 ☐ Yes 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) examiner?

1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 27. Manne of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation M 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical 29a. Certifier 1🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar

State

29b. Signature and title of certifier

Brian Euche

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MI

1105. Paca ST

32 Registrar's Signature

sixth floor seite 200

29d. Date signed (Month, Day, Year)

the death certificate be executed P.O. Box 68760, Division or Vital Records,

Physician

Examiner

Funeral

Director

r 28a-f show notified at show

r than "natural", or items 23a or the Medical Examiner must be

if of Health and Mental Hygiene.
If item 27 is marked other than or other traumatic event, the Menother traumatic event.

Department of Important: If any Injury or once.

Physician /Medical

Examiner

signed by the attending physician I be detached for use as the buria

ate has been sign page 2 should be

Examiner

Physician/Medical

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Completed

Be

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Certification:

Medical

3 ☐ Suicide

29a. Certifier

4 Homicide

death

filed within 72 hours after

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Pages 1 and 2 should

Maryland 21215-0036

Baltimore,

Director

Funeral

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Completed

/Medical

after death.

I Director: After this d in by the funeral di ō To the Hospital within 24 hours a To the Funeral I

> State Registrar DHMH 17 Rev 1/2001

completely filled

Reale 31. Date filed (Month, Day, Year)

and manner stated.

29c. License number D 50653

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

20751

28f. Location (Street and Number or Rural Route Number, City or Town, State)

GYAN .C. SUPANA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Road

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

5851 -Churchton

6 ☐ Could not be

32. Registrar's Signature

Deneva

29b. Signature and title of certifier

		ľ	For State Registrar	State of M	aryland		artmen rtificat			and M	_	gien Reg. N	-2 N N	9	132	290
	D I		1. Decedent's Name (First, Middle, Las	et)			-				2. Date of De		ay Y	ear	3. Time of	Death
	Physici /Medic			Victor H	lerber	t Lyon	ns				April	22,	2009	oui	2:30	PM
16	Examir		4a. Facility Name (If not institution, give				4b. City,	Town, or	Location o	f Death			c. County of I			
			Laurel Regional				Lau		If I laday I	0411== 1			Prince			
	Funeral		5. Social Security Number 6. S	ex		ast birthday) Yrs.	If Under Months	Days	If Under :	Min.	8. Date of Birl (Month, Da	y, Yea	r) 9.		olace (State o ntry)	r Foreign
	Director		579-46-1060 Usual Residence of Decedent		79						Apr 10	, 1	930	Ohi	.0	
	land ow It		10a. State 10b. County		10c. City	, Town or Lo	cation							1	0d. Inside Ci	ty Limits
	Mary f sh	tor	MD Anne Aru	ındel	Lau	ırel									1 ☐ Yes	2 🛚 No
	r 28a	irec	10e. Street and Number				10f. Zip	Code				10g. C	itizen of Wha	at Cour	ntry?	
	n with	Funeral Director	359 Dameron Sout	:h			20	724				U.	S.A.			
	deat	nera	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S	S. 13.	Was Deced	dent of Hi	spanic Orig	gin? (Spe	ecify Yes or No Rican, etc.)	-	14. Race - Black,			
9	after or Ite	, Fu	1 ☐ Never Married 2 🔀 Married	1 ŽAYes 2 □	No		1 ☐ Yes		Specify:	i, i dono	mount, oto.)		Specify:	vville,	eic.	
93	ours ral", Exa	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	1948-	.52							V	√hi		
5-	72 h "natu	ete	15. Decedent's Ed (Specify only highest gra	lucation de co <i>mpleted)</i>		16a. Dece	dent's Usua kind of wo DO NOT us	al Occupa rk done d	ation Juring most	t of worki	ng	16b.	Kind of Busin	ess/In	dustry	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show he Medical Examiner must be notified at	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)		le Sp.					m _c	elephor	20 (Company	T 7
	filed within I Hygiene. other than ent, the Me		17. Father's Name (First, Middle, Last)			Cab.	re sp.	iice.		r's Name	(First, Middle,			ie (Julipan	У
an	d be entai	o Be	Victor St. Clair						F1f1	a ha	Belle S	nor	100			
Maryland	shoul nd Me mark	2	19a. Informant's Name/Relationship (19b. Mailir	ng Address	(Street &			I Route Numb	_	-	ate, Zij	Code)	
	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hyglene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		Angela J. Lyons	/spouse		359	Dame	ron :	South	. La	urel, M	larv	land 2	207	24	
ē,	s 1 a of Hea item othe		20a. Method of Disposition		0.0	lace of Dispo emetery, crea	sition (Nar	ne of	i		ate		Location - Cit			
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other		1 XXBurial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify			dowri			i	Apr	25, 09	Do	orsey,	Mai	ryland	
alti	permit. DepartmImporta any inju		21. Signature of Funeral Service Licen	isee]		2	2. Name an	d Addres			Home, F					
m	o a L o		Wolff, in	1/2	M0077						aurel,			201	707-438	89
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause one cause on each I	d the death ine.	. Do not en	ter the mod	e of dyin	g, such as	cardiac c	or respiratory a	rrest,			Approximate Interval Bet	e ween
-	Physician		Immediate Cause (Final disease or condition	Bilate	ral p	neumor	nia								Onset and I LO days	
~	/Medical		resulting in death)	Due to (or as	a consequ	ence of):										
	Examiner	L	Sequentially list conditions,	b. Conges			Fail	ıre								
	ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as				3		D						
	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Examiner	that initiated events resulting in death) Last	c. Arteri			car	llova	ascul	ar D	isease					
8760,	be ey ician buria	ical E	6	24010 (0) 41												
387	phys phys	dic		- d										\pm		
Box 6	certif iding ise at	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	e pf pregna	ncy							23d. Date of	of deliv	erv	
ğ	death atter	ciar	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐Live birth 4 ☐ Pregnant a			⊒Ectopic pi ⊒ Other <i>(sp</i>						Month		*	Year
0	uires that the de signed by the a Id be detached f	hysi	9 ☐ Unknown	9□Unknown												
о, С	s that ned b	by P	Part II. Other significant conditions	ontributing to death	but not resu	ılting in the u	nderlying c	ause give	en in Part I.		23e. Did t	obacco	o use contribu	ite to t	he cause of d	leath?
Records,	w require been sig should b	ed b	Renal Failure								1 🗆 '	Yes	2 No 3	☐ Prol	bably 4 ∑ l	Jnknown
ပ္ပ	aw requisite been 2 should	olet									24a. Was		24b. We	re auto	psy findings impletion of c	available
Ä	The I	Completed									auto perfo	rmed? 2 XI	dea	ith?]Yes	2 No	ause oi
Vital	lan: rtifica stor, p	Be C	25. Was case referred to medical examiner?						26. Place	of Death	(Check only o					
or V	Physician: r this certific ral director,	To	1 Yes 2X No	Hospital: 1 XInpat	ient 2□I	ER/Outpatie	nt 3 □ DC	OA Othe	er: 4□ Nu	rsing Ho	me 5□Resi	dence	6 □Other	(Speci	fy)	
0	ng Pl		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inj (Month, D	ury ay Year)	28b. Time o Injury		28c. Injun Work			28d. Describe	how in	jury occurred			
Sio	Attending r death. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be				М		Yes 2			21 1				
Division	or Att	Certification:	4 Homicide determined	28e. Place of in	ijury - At ho tc. <i>(Specif</i> y	me, farm, sti	reet, factor	y, office		1	28f. Location (City or To			or Run	al Route Num	iber,
	pital ours a eral [ဦ	29a. Certifier 1 ★Certifying Ph	ysician: To the bes	t of my know	wledge deat	th occurred	at the tin	ne date ar	nd place	and due to the	Calleo	(e) and mann	or ac s	etated	
	Hos 24 hc Fun etely	Medical		niner: On the basis and manner s	of examinat											3)
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Me	29b. Signature and title of certifier	D			29	c. License	e number			29d. D	Date signed (/	Month,	Day, Year)	
	- 1)	TOO	2	No	\	2472	21			Apr	il 23,	20	009	
,	15+		30. Name and address of person who	completed cause of	death (Item	23a) (Type,	Print)									
	1 1		Syed Sadiq, M.D				Le Roa	ad, s	Ste 2	08, 1	Laurel,	Ma	ryland	20	708	
P	St	ate	31. Date filed (Month, Day, Year)		irar's Signa	ture	1-0	0								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend #18 per FH g890 4.29.09 TT
State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 4 **Physician** 10:42 PM Florence Ann Lipscomb /Medical Baltmore City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Damaritan HOSDITA If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Hours Days 1 M 2 XF 220-34-9295 Yrs Director 70 08 22 MD Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b County 10c. City, Town or Location 10a, State show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Project Examinar must be notified at 1 ☐ Yes 2 No **Funeral Director** Parkville MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2209 Pentland Drive Apt B U.S.A. 21234 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 1 ☐Yes No Specify: Specify: Black ģ 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry ementary/Secondary (0-12) College (1-4or 5+) 10th grade na Cook Charles Village Pub 18. Mother's Name (First, Middle, Maiden Surname) **Anna Pearl Acree** Maryland 17. Father's Name (First, Middle, Last) Health and Mental should be Peare 2 Clayton Wicks Sr. Anna 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Wicks-Daughter 5535 Cedonia Ave, Baltimore, Md 21206 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages ' fo Durial 2 ☐ Cremation 3 ☐ Removal from State ☐ Donation 5 ☐ Other (Specify) injury or Department of Important: If any injury or King Memorial Park 4/25/09 Woodlawn, Md 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, Md 21215 21. Signature of Funeral Service Licenses al Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Intracerebral hemorr has disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 ☐ Ectopic pregnancy for Month Day Year 5 Other (specify) the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of peath? à sate has been signi page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗖 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy ormegr/ 2. ☑ No 2 No 1 □Yes 1 ☐ Yes 25. Was case referred to medical funeral director Be 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation the within 24 hours after death To the Funeral Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MI U4.20.04 30. Name and address of person the completed cause of death (Item 23a) (Type, Print) Good Sumantan Courtney Toomey 5601 Loch Raven Boulevard Buthmore, MD Good Samantan Hospital

State Registrar

Florence

Sem

a

31. Date filed (Month, Day, Year)

APR 27 2009

32. Registrar's Signature

		1 - State of Mary State of Mary Registrar		rtment of He tificate of D			ne _{No.} 2009	13292
Physic /Med		1. Decedent's Name (First, Middle, Last)	,VIN			2. Date of Death Month April 21,	Day 2009 Year	3. Time of Death 1:45 pm
Exami		4a. Facility Name (If not institution, give street and number) Glen Burnie Health & Rehabilitation	on	4b. City, Town, or Lo Glen Bur			4c. County of Dea Anne Art	
Funera Directo		5. Social Security Number 6. Sex 1 ☐ M 2 ■ F 7. Age (I	n yrs. last birthday) 82 Yrs.		f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye October 7,	1926 Ma	thplace (State or Foreign punity) ryland
laryland show	j.		oc. City, Town or Loo					10d. Inside Cify Limits 1 □Yes 2 No
with the M la or 28a-1	Funeral Director	Maryland Anne Arundel 10e. Street and Number 504 Sylvan Way	rasa	10f. Zip Code	.22	10g.	Citizen of What Co	,
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	Ş	11. Marital Status 1	l If	Vas Decedent of Hisp Yes, specify Cuban, □Yes 2【No	panic Origin? (Spe Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
21215-0036 d within 72 hours aft giene. er than "natural", or i, the Medical Exami,	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give I	ent's Usual Occupati kind of work done dur DO NOT use retired) pendant		ing 16t	None	/Industry
Maryland of the filed atth and Mental Hyu 27 is marked other traumatic event,	To Be C	17. Father's Name (First, Middle, Last) Andrew Lee Melvin		11	8. Mother's Name Eleanor	(First, Middle, Maid Marie	den Surname) Kelly	
Mary and 2 shot salth and N 27 is ma er trauma		19a. Informant's Name/Relationship (Type. Print) Ruth F. McKenna (Sister in Law)	1	g Address <i>(Street and</i> Sy lvan Way,			ty or Town, State, . 21122	Zip Code)
Baltimore, permit. Pages 1 ar Department of Hea Important: If item: any Injury or other once.		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	20b. Place of Dispos cemetery, crem Cedar Hill	sition (Name of natory or other place) Cenetery	04-24-		. Location - City or oklyn Park	
Balt permit. Depart Import any Inj		21. Signature of Fundral Service License	// 22. Mc	Name and Address Cully-Polyni	of Facility i.ak Funera	1 Home P.A.	3204 Mounta Pasadena, M	in Road aryland 21122
Physician /Medical Examiner	23 1	23a. Bot 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. In mediate Cause (Final isease or condition resulting in death) Due to (or as a condition or as a condit	e death. Do not ente	TN Pn	such as cardiac o			Approximate Interval Between Onset and Death
68760, Ifficate be executed g physician and as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to himmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a condition of the		0517				-111
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending pl completely filled in by the funeral director, page 2 should be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknowh 23c. If yes, outcome of past 12 in the past 12 months? 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
rds, P quires that an signed build be deta	Ď	Part II. Other significant conditions contributing to death but n	ot resulting in the un	derlying cause given	in Part I.		co use contribute to	o the cause of death?
al Records, The law requires the cate has been signe, page 2 should be cate.	Completed					24a. Was an autopsy performed 1 ∐Yes 2	prior to	utopsy findings available completion of cause of
on of Vital Reding Physician: The Information of the Affer this certificate his teneral director, page	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient	2 ER/Outpatient	Othor		n (Check only one) me 5 ☐ Residence	e 6 ☐ Other (Spe	cify)
Division of Vital of Attending Physician: Tafer death. Director: After this certificat Lin by the funeral director, pa	ation:	27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day, Ye	28b. Time of Injury	28c. Injury a Work? M 1 □ Ye	s 2 □No	28d. Describe how in	njury occurred	
Division tal or Attend rs after death al Director: , ed in by the f	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury building, etc. (4	- At home, farm, stre Specify)	et, factory, office	2	28f. Location <i>(Stree</i> City or Town, S		ural Route Number,
he Hospi in 24 hour he Funer pletely fill	edical	29a. Certifier (Check only one) Certifying Physician: To the best of m 2 Medical Examiner: On the basis of ex and manner stated	amination and/or inv	occurred at the time estigation, in my opin	, date and place, nion, death occurr	and due to the caus ed at the time, date	e(s) and manner a and place, and due	s stated. to the cause(s)
To t with	Ž	29b. Signature, and title of solitifier)	29c. License n	1838		Pate signed (Mont	1, 2009
3 v		30. Name and address of person who completed cause of death	1 (Item 23a) (Type, F	Print)		PAN: LI	NIDH !	cun no
St Regist	ate rar	31. Date filed (Month, Day, Year) 32. Registrar's	Signature	Print) TO HON		,	/	11
DHMH 17 Rev 1/2	2001	ATK 2 1 2009 Chance	1. 19ª	1/Care				

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	Otate of Ma	ii yianu		tificate of		ментат пус	Reg. No.2	109	13293
	Physici /Medio		1. Decedent's Name (First, Middle, La Catherine Ma	rie Muhl	у				2. Date of Dea Month April 22	ith	Year	3. Time of Death 7:25 A M
	Examir	er	4a. Facility Name (If not institution, given 1101 Nanticoke St				4b. City, Town, o	r Location of Deat	1		ty of Death	
Ī	Funeral Director		5. Social Security Number 6. 8 216-48-4023		(In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birti (Month, Day	h /, Year)		
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Loc	ation		, , , , , , , , , , , , , , , , , , ,	1.742		0d. Inside City Limits
	a-f sh	ctor	MD N/	A		timore						1 TyYes 2 □ No
	th with the 23a or 28 ust be not	ral Director	10e. Street and Number 1101 Nanticoke Str	reet			10f. Zip Code 21230			10g. Citizen of USA	What Cour	itry?
9800	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, I'm Medical Exertiver cust be notified at aumatic event, I'm Medical Exertiver.	d by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 🙀 Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1			Vas Decedent of H Yes, specify Cub □Yes 2 1 No	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- Rican, etc.)	Bla	ace - Americ ack, White, e	etc.
15-	in 72 h "natu	olete	15. Decedent's Ed (Specify only highest gra	ade completed)		16a. Deced (Give I	ent's Usual Occup aind of work done	oation during most of word d)	king	16b. Kind of B	Business/Ind	dustry
212	d with	Completed	Elementary/Secondary (0-12)	College (1-4or 5+		cashie				retail		
yland	uld be file Mental H) arked oth atic event	To Be (17. Father's Name (First, Middle, Last, James Anderson Conway					18. Mother's Nam Bernadine	e (First, Middle, Cheelsman		пе)	
baltimore, Maryland 21215-0036	pormit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic egics.		19a. Informant's Name/Relationship (Wayne Beatty	Type. Print) SON		1101 N	anticoke S	and Number or Ru t. Baltimor	ral Route Numbe e, MD 2123	r, City or Town	, State, Zip	Code)
Imore	. Pages 1 tment of H tant: If iter jury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State (20b. Plac cem rownsv	ville V		metery 4/28	/2009	20c. Location rownsvil	le, Ma	ryland
n n	permit D part Import any Inj once.		21. Signature of Funeral Service Licer	NovACO		22. 237	Name and Addre	ss of FacilityMcCu co Ave. Bal	11y Polyni timore, M	ak Funer 21225	al Hom	e P.A.
2000	hysician /Medical		23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line).				or respiratory arr	est,		Approximate Interval Between Onset and Death
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OISIAI	frer death.	Certification: T	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		/ - At home	, farm, stree	M 1 □	Yes 2□No	28f. Location (St. City or Town	reet and Numb	er or Rural	Route Number,
ב !	Funeral D	-	Check only 2 Medical Exam	ysician: To the best of niner: On the basis of e	examination	dge, death	occurred at the tirestigation, in my o	ne, date and place,	and due to the cred at the time, do	ause(s) and ma	anner as st	ated.
4	vithin 2 o the	Medical	29b. Signature and title of certifier	and manner state	ed.		29c. License			9d. Date signer		
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9	X V		30. Name and address of person who of An, ta Khande			a) (Type, Pi	int) 1 S. Ha	52490 nover 8	St Ba	et m	0 2	1225
	Stat Registra	~	31. Date filed (Month, Day, Year)	32. Registrar's	s Signature							

DHMH 17 Rev 1/2001

APR 27 2009 Denne B. Sparke ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 3294 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician James Ρ. Mason A M April 20 2009 4:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Riviera Beach Anne Arundel Coralwood Road If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Months Days Hours 220-60-8730 57 Director 5 1951 Maryland August Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If fine 72 is marked other than "natural" or linear or other trainment. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Anne Arundel Maryland Riviera Beach **Funeral Director** 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Coralwood 21122 USA 124 Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? MYes 2 ☐ No 1 MYes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Completed by Specify: White 3 Widowed 4 Divorced 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Plumbing Supply Co. 12 Purchasing Agent 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mason Geraldine Tysinger 2 Jay 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Wife) 124 Coralwood Road, Riviera Beach, Maryland 21122 Kathleen M. Mason 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 04/24/2009 Glen Haven Mem. Pk. Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 3204 Mountain Road, Pasadena, Maryland 21122 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Merestatte adenocarcizama **Physician** Signer-ring unknown 5 weeks /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 5 ☐ Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 📈 No 3 ☐ Probably 4 🗍 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 □Yes 2 No 1 ☐ Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \(\sum \) Nursing Home 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 X Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No neral Director: / 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier mark 6. Goldstein, nD 29d. Date signed (Month, Day, Year) 29c. License number D006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print).

MACK G GULDSTEIR) MD 1630 MAIN ST SUITE 304 CHESTER MA

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

Box 68760.

P.O.

Division of Vital Records,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 40 A M APRIC Rge 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Amedical Center BALTIMORE A TMOR If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Social Security Number 6. Sex Days Hours **X**□M 2□F 81 02 28 04 SC 219-22-3318 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1X Yes 2 □ No Baltimore NA MD Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21215 3821 Lewin Ave Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 X Yes 2 □ If Yes, Give Year or Dates: 2 □ No 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2√☐ No Specify: Specify: Black ò 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) State Of Maryland Security Officer na 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Susie Robinson Arthur McGee 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3821 Lewin Ave, Baltimore, Md 21215 Gregory Page-Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Owings Mills, Md Garrison Forest Vet 4/27/09 21. Signature of 22. Name and Address of Facility
March F/H West Funeral Service Licensee 4300 Wabash Ave, Baltimore, Md 21215 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS 2 days Due to (or as a consequence of): 2 days pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (br as a consequence of): Examine Due to (or as a consequence of): by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 201 No 1 Tes 1 Dunpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Division or Vital Records, P.O. Box 68760,

attending physician and for use as the burial-transit signed by the a d be detached for has To the Hospital or Attending Physician: this within 24 hours after death.

To the Funeral Director: #

Funeral

Director

28a-f show

iral", or items 23a or 28a-f sh Examiner must be notified

and 2 should be filed within 72 hours after on ealth and Mental Hygiene. n 27 is marked other than "natural", or iten

permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra

Physician

/Medical

Examiner

traumatic event, the Medical

3altimore, Maryland 21215-0036

death with the Maryland

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medica (Check only one) отpletely and manner stated. 29b. Signature and title of certifier oller M.O 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. CHAUDHRI 31. Date filed (Month, Day, Year) Registrar's Signature State

determined

29c. License number

APR 27 2009

4 | Homicide

Registrar

Please Type or Print in Black Indelible lnk. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 5:00 M 1. Decedent's Name (First, Middle, Last) 2. Date of Death Nicholson Month Day Year Grace Mackenzie 000 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Battimore UMMC If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number NA Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) Min. Months Days Hours. 1 □ M 2 🛛 F 04/22/2009 38 MD Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County Y⊟Yes 2 No MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 3733 Elmora 21213 Ave. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1X Never Married 2 ☐ Married 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates: Specify Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NA Ò NΑ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) George M. Nicholson Lisa Nicholson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa Nicholson/ Mother 3733 Elmora Ave.Balto., MD, 21213 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3
Removal from State Metro Crematory 04/27/09 Catonsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wylie Funeral Home P.A. 21. Signature of Funeral Service Licensee Gilmor St Balto MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ansmah MU disease or condition resulting in death) Due to (or as a consequence of) 10 1 MM of delivery Day Year ibute to the cause of death? 3 Probably 4 Unknown Nere autopsy findings available prior to completion of cause of death? □Yes 2 No

Physician /Medical Examiner

attending physician and for use as the burial-trar

cate has been signed by the page 2 should be detached

certificate

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within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

funeral director,

Le, artment of mportant: If it ny Injury or o

Physician

Examiner

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ary or other traumatic event, I'm Medical Expiriment at the matthed at

Baltimore, Maryland 21215-0036

/Medical

Director

Funeral

2

Completed

Be

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Physician/Medical Examiner Be Completed by Medical Certification: To

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 9 Unknown	23d. Date of delivery Month Day Year
Part II. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death
		24a. Was an autopsy performed? 1 □ Yes 2 ⊠No 24b. Were autopsy findings ava prior to completion of caus death? 1 □ Yes 2 ☑ No
25. Was case referred to medical	26. Place of Death ((Check only one)
examiner? 1 ☐ Yes 2 █ No	Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home	e 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1	(Month, Day, Year) Injury Work?	3d. Describe how injury occurred
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	8f. Location (Street and Number or Rural Route Number, City or Town, State)

State Registrar

31. Date filed (Month, Day, Year)

29a. Certifier

(Check only

29b. Signature and title of certifier

an ou

30. Name and address of person who completed cause of death (Item 23a) (Type University 32. Registrar's Signatur

and manner stated.

D0062150

29d. Date signed (Month, Day, Year)

🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

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Physician Regina Nekludov Regina Nek			For			State o	of Mai	yland	d / De	partme	nt of I	Health	and M	1ental F	Hygier	ne 2 (009		329
Regina Nekludov Regina Nekludo										ertifica	ite of	Death				No.			
Reginal Next Indo Sample Reginal Next Indo	Physicis	an.	Decedent's Nam	ne (First, Midd	le, Last)									Month	[
Substitution Subs														Apri.				12:	00 P M
Secular Security Number 10 Security Num	Examin	er	4a. Facility Name (If not institutio	n, give st	treet and nu	umber)			4b. Ci					'	4c. County	y of Death		
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173-26-8577 150-161 94 95 150-161	Funeral		Social Security N	Number		M OLD E	7. Age	(In yrs. l		Month				l (Month.	Dav. Yea	ar)	Coui	ntry)	ate or Foreigi
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Division of Vital Records, P.O. Box 68760, To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the

Baltimore, Maryland 21215-0036

State

Medical Certif

29a. Certifier (Check only one)

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

D23124

April 22, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3300 Olney-Sandy Spring Road, Suite 330, Olney, MD Dr. Hannon,

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 3. Time of Death 1. Decedent's Name (First: Middle, Last) 2. Date of Death MARY CATHERINE NOVAK April 20, 2009 9:20 Рм 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Baltimore Catonsville Summit Park Nursing Home 8. Date of Birth (Month, Day) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday Months Maryland Days Hours 1 □ M 2 🛛 F 218-19-6083 86 July 10. Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location **Baltimroe** N/A Maryland 1 X Yes 2 No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1618 Belt Street 21230 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2X Married 1 ☐ Yes 2 No White Specify: Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) Homemaker (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Housewife 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Riggin Teresa Kuschel 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Frank James Novak, Jr.-Hushand 1618 Belt St., Baltimore, Maryland 21230 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery Baltimore, Maryland 04-24-09 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McCully—Polyniak Funeral Home, P.A. 237 Fast Patapsco Avenue, Baltimore, Maryland 21225—1 Signatur of Furtal Service Licensee Kevin E Ecker 21225-1856 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final lay disease or condition resulting in death)

Physician /Medical Examiner

attending physician and for use as the burial-tran

certificate has the irector, page 2 sl

Physician

/Medical

Examiner

10a. State

Funeral

Director

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Health and Mental Hygiene. 77 is marked other traumatic event, I

permit, Pages 1 and 2:
Department of Health at
Important: If item 27 is
any injury or other trau

Baltimore, Maryland 21215-0036

Be Completed by Physician/Medical Examine Medical Certification: To within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

the Hospital or Attending PhysIclan: The law requires that the death certificate be execute

Division of Vital Records, P.O. Box 68760,

	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a conseq c. Due to (or as a conseq d.	uence of):	islay,) week		109
185	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	il death 3 ☐ Ectopic			23d. Date of deliver Month	very Day Year
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	25. Was case referred to medical			26. Place of De	ath (Check only one)		
	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 🗆 🗈	OOA Other: 4 Nursing	Home 5 ☐ Residence	e 6 ☐ Other (Spec	ify)
	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in		
	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Special	ome, farm, street, facto	ry, office	28f. Location (Street City or Town, St	and Number or Ru ate)	ral Route Number,
	29a. Certifier 1 ertifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my knowniner: On the basis of examination and manner stated.	owledge, death occurre ation and/or investigation	d at the time, date and pla on, in my opinion, death oc	ce, and due to the caus curred at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	29b. Signature and title of certifier		29	9c. License number DD944		Date signed (Month	, Day, Year)
	30. Name and address of person who	2 //	m 23a) (Type, Print)	Feny Rd	2122	>	

State Registrar

31. Date filed (Month

32. Registrar's Signature

1	egin	A	Peterson				
09-030	91		Please Type or Print in Black Indelible Ink. Ensure All Copie State of Maryland / Department of Health and Mental Hy	s Are Leç vaiene	jible.	200	9 1329
UNK L	JNK		- For State Certificate of Death	Re	g. No.		ne of Death
	Physicia		egistrar I. Decedent's Name (First, Middle,Last)	2. Date of Deat Month April 18, 2	Day \		000 hrs
Me.	Examir	ier	Regina Peterson 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death			ty of Death	
		4	1429 North Broadway Baltimore			YY) 9. Birthplac	e (State or
	Funeral	5	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs Months Days Hours Min		6/200	Foreign	
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10	vith the Maryland s 23a or 28a-f show e notified at once.	Director	10e. Street and Number		log. Oilizon o		
407	h the N 3a or	희	1429 N. Broadway St. 21213 14 Moritol Status 12, Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S	Specify Yes or N		USA Race - American II	ndian, Black,
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	5-0036 iled within? Hygiene. Jother than	Comple	17. Father's Name (First, Middle, Last)				
	21215 buld be fill Mental F marked ic event, t	B	Reginald Peterson Rho 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number o	nda Wi r Rural Route N	umber, City o	Town, State, Zip	Code)
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	altimore, rmit Pages I ar spariment of He aportant: If ite		4 Donation 5 Other Specify: Trinity Cemetery	/24/09	Dund	alk,MD	P . A .
	Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mannal Hygiera. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Puneral Service Education	G. Bal	+ 0 M	a 2121	7
19	vsiciar	_	23a Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia	c or respiratory	arrest, shock,	or heart A	Approximate Interval Between Onset and Death
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	Box 68760, e death certificate be the attending physic	M/ug	FEMALE: 23b. Was decedent pregnant in the past 12 months? 25c. if yes, outcome of pregnants. 1 Ectopic pre	egnancy	M	onth Day	y Year
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(2	Division To the Hospital or Attend within 24 hours after death To the Finneral Director:			e, and due to the	cause(s) and	manner as state be, and due to the	d. e cause(s)
(Ju	To the Within 7	omplet	one) 2 Medical Examiner:On the basis of examination and/or investigation, in the part of the basis of examination and/or investigation, in the part of			Date signed (Mor	
-1			29b. Signature and title of certifier O.C.M.E.		Apri	18, 2009	
4	_		30. Name and address of person who completed cause of death (Item 23a)				
0			Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, M	21201 טו			
		Sta	te 31. Date filed (Month, Day, Year) 32. kegistrar's Signatur				

DHMH 17 Rev 1/2001

ORIGINAL

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			e (First, Middle, Last)	State of Maryla per fh,g890		inicate or	Death	2. Date of De	ath		3. Time of Death
	sician edical	Kather		oulson				April 2	20, Day 20	09 ^{Year}	7:00 a M
Exa	miner	4a. Facility Name (if not institution, give s nya Road	reet and number)		4b. City, Town, o	or Location of Death Lstown	1		ty of Death	e
Fune Direc		5. Social Security N 213–34–0) 94 0 1 □	7. Age (In yrs	. last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Bir (Month, Da 01/06/1	th ly, Year) L 931	9. Birthp Cour Mary	
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in 72 hours after death with the Maryland in natural", or items 23a or 28a-f show	ed by Funeral	11. Marital Status 1 □ Never Marr 3 🏋 Widowed	ried 2 ☐ Married 4 ☐ Divorced	2. Was Decedent Ever in U Armed Forces? 1 _Yes 2 \(\) No If Yes, Give Year or Dates:		fYes, specify Cub I⊡Yes 2 X No	Hispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	Spec		etc. .ack
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eath certificate be executed attending physician and for use as the burial-transit	edical Examiner	Sequentially list colif any, leading to im cause. Enter Unde Cause (Disease or that initiated events resulting in death) I	amediate orlying injury	Due to (or as a consec							
Hospital or Attending Physician: The law requires that the death certificate be executed 4.4 hours after cleath. Funeral Director: After this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent in the past 12 1 □ Yes 2 [9 □ Unknown	months?	c. If yes, outcome of pregn 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	aldeath 3 [Ectopic pregnanc	у			ate of delive	ery Day Year
quires tha en signed uld be del	þ	Part II. Other signif		ibuting to death but not res	sulting in the ur	derlying cause giv	en in Part I.	23e. Did to			ne cause of death?
ding Physician: The law requir After this certificate has been s funeral director, page 2 should	Completed							24a. Was autop perfo 1 Yes		were auto prior to con death? 1 □ Yes	psy findings available mpletion of cause of 2 □ No
nysicia nis certi directo	lo Be	25. Was case reference examiner? 1 ☐ Yes 2 【	Но	spital:] ER/Outpatien	t 3 DOA Oth	26. Place of Deat er: 4 ☐ Nursing Ho	th <i>(Check only o</i> ome 5 ☐ Resid		ther (Specif	(v)
ttending Pr death. stor: After th	Certification: T	27. Manner of Death 1 XNatural 2 Accident 3 Suicide	5 ☐ Pending investigation 6 ☐ Could not be	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury		y at	28d. Describe h	ow injury occu	ırred	
pital or A urs after ral Direc		4 Homicide	determined	28e. Place of Injury - At h building, etc. (Speci	<i>ty)</i>			City or Tow	n, State)		l Route Number,
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	oney	2 Medical Examine	cian: To the best of my known: On the basis of examination and manner stated.	owledge, death ation and/or inv	occurred at the tile estigation, in my control	me, date and place ppinion, death occur	, and due to the red at the time,	cause(s) and r	manner as s e, and due to	tated. the cause(s)
To To t	2	29b. Signature and	title of certifier	9		29c. Licens			29d. Date sign April 2		
F				pleted cause of death (Iter			oads. Sui	te 100.	Baltin	nore.	MD 21228
	State	31. Date filed (Mont		32 Registrar's Signa			,				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 0700 M JOSEPH PIECHOTA APRIL 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A HARBOR HOSPITAL 8. Date of Birth (Month, Day, Year April 7 1921 Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 M 2 □ F 88 Maryland 214-12-2188 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State ir than "natural", or items 23a or 28a-f show the Medical Expendies naist be notified at 1 →Yes 2 □ No MD N/A Baltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 312 Washburn Avenue 21225 USA Funeral 12, Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☐No If Yes, Give Year or Dates: Specify: White Specify: þ 3 ₩ Widowed 4 Divorced WIT Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 is marked other than any Injury or other traumatic event, the Manging. Electrician Electrical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Anthony Piechota Sr. Marie Rzucidlo ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Joseph M. Piechota -Son 312 Washburn Avenue Baltimore, Maryland 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Holy Cross Cemetery April 27, 2009 Brooklyn Park, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility McCully Polyniak Funeral Home P.A. 21. Signature of Funeral Service Licensee 237 E. Patapsco Avenue, Baltimore, MD 21225 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ,, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final discuss or condition resulting in death) **Physician** PNEUMONIA ASPIRATION /Medical Due to (or as a consequence of) **Examiner** DISEASE PARKINSONS Sequentially list conditions, if only localing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Hospitel or Attending Physiclan: The law requires that the deeth certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the s ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No CONGESTIVE HEART FAILURE, ATRIAL FIBRILLATION, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ◯ No CHRONIC OBSTRUCTIVE PULMONARY DISEASE 2 No 1 ☐ Yes 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospitel or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral directorial death of the funeral directory. Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27, Manner of Death 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 184Dys Bhowane RES OOL APRIL 24 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) REDNAM 3001 SOUTH HANDVER STREET BALTIMORE, MD 21225 GIANGA 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 13302 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 16 **Physician** ^{Day} 2009 11:00 a.M Estella Price /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3739 Nortonia Road Baltimore n/a If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Y 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🔀 F Months Days Hours Min Director 214-26-6777 S.C. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Items 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the "sector Evantment is use to other 1 √Yes 2 □ No Funeral Director Baltimore 10e. Street and Number 0f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 any living or other traumatic event, the Medical Experimental Once. 3739 Nortonia Road 21216 USA 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: specify: African-American þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Department Store 9th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Ernest Feaster Sallie Simpson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce King/ Niece 9710 Hollystone Lane, Charlotte, N.C. 28215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 □ Cremation 3 □ Removal from State Chester Mem. Gardens 4-22-2009 Chester, South Carolina 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wylie Funeral Home P.A. of Baito. Co. 21. Signature of Funeral/Service Licensee 9200 LibertyRoad, Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final **Physician** lunp caucel disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** ingressen Hon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 146 2 NO 1 ☐ Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After **Natural** 5 Pending investigation within 24 hours after death.

To the Funeral Director: Af 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier ' Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0005 9228 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Print) Old Court Rd., S. 204 Raw dates foun, Up. 211 M. N 5400 E. PASMANDI 31. Date filed (Month, Day, Year) Pogistrar's Signature State Registrar

DHMH 17 Rev 1/2001

Box 68760.

P.0.

Division of Vital Records,

State

31. Date filed (Mor

30. Name and address of person who completed cause of death (Item 23a)

29b. Signature and title of certifier

Jack Titus MD.

Deputy Chief Medical Examiner

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

Registrar

29d. Date signed (Month, Day, Year)

April 19, 2009

State Registra

29b. Signature and

PATRICK

of certifier

TURNES

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

SUITE 102, 1000 LIBERTY RD., ELDERSBURG,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Cornelia Snowden Nancy 5:40a. 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Catonsville Manor Care Nursing Home Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 🖫 F Months Hours 91 Director 06 26 VA 219-38-8110 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County other traumatic event, the Midical Examinar must be notified at Funeral Director Baltimore 1X Yes 2 □ No MD NA 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21244 U.S.A. 8314 Lages Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. 1 Tes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 ☐ No Specify. Be Completed by 3 ☑ Widowed 4 ☐ Divorced Black 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Segall Majestic 7th grade Packager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Mary E. Price Edward Lee Hubbard 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8314 Lages Lane, Baltimore, Md 21244 Laura A. Richardson-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If Its any Injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State New Shiloh Donation 5 ☐ Other (Specify) Baptist Church 5/1/09 22. Name and Address of Facility Nathalie, VA 21. Signature of Funeral Service License March F/H West 4300 Wabash Ave, Baltimore, Md 23a. Parl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line. 21215 Immediate Cause (Final peremonice disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE 23d. Date of delivery Day use contribute to the cause of death? □ No 3□ Probably 4◘ Onknown 24b. Were autopsy findings available prior to completion of cause of death?

Physician /Medical Examiner

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

pital or Attending Physiclan: The law requires that the death certificate be executed ours after death.

eral Director: After this certificate has been signed by the attending physician and filled in by the functor afterctor, page 2 should be detached for use as the burial-transit Be Certification: To within 24 hours To the Funeral Medical

23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 WNo 9 □ Unknown	23c, if yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	23d. Date of deliver Month
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the
MULTI NO	DULLAR GOITKE	1 ☐ Yes 2 ☐ No 3 ☐ Proba
		24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autops prior to come death?
25. Was case referred to medical	26. Place of Death (C	theck only one)
examiner? 1 ☐ Yes 2 XNo	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home	5 Residence 6 Other (Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Mork? 1 Yes 2 No	. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Examine: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examine: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) Certifie 29b. Signature a 100051765 04-21-2009

2 000

Hospital

State Registrar

EBENEZEN QUHINOS 31. Date filed (Month, Day Year)-

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OLD 3350 WILLER'S AUE #307 BALT.

			T- State of Marylar	•	artment of F		-	giene 2009	13306
ı	Physici		Decedent's Name (First, Middle, Last) SONDRA	SHAP	0\$		2. Date of Dea		3. Time of Death 5:15 A M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) MANOR CARE			r Location of Death		4c. County of Dear	RE
ı	Funeral Director		5. Social Security Number 215-07-4953 6. Sex 1 □ M 2 1 1 F 95	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da 06/08/	9. Bir 1913	thplace (State or Foreign buntry) NY
	laryland show	o.	,	ity, Town or Lo					10d. Inside City Limits 1 🕅 Yes 2 □ No
	with the Na or 28a-f	I Director	MD N/A 10e. Street and Number 3601 FORDS LANE, APT. 501	BALI	IMORE 10f. Zip Code 212	15		10g. Citizen of What Co	puntry?
0036	I within 72 hours after death with the Maryland siden. Jiene. T than "natural", or Items 23a or 28a-f show the Modical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in UArmed Forces? 1 Pes 2 No If Yes, Give Year or Dates:			dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
0-6121	72 "inat	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired IEMAKER	durina most of work	ing	16b. Kind of Business.	
/land 2	be filed ntal Hyg od othe event,	To Be Co	17. Father's Name (First, Middle, Last) RUBIN	COHEN		18. Mother's Name	, , ,	Maiden Surname)	ALLESBAND
, Mar)	nd 2 sh alth and 27 is m r traum		19a. Informant's Name/Relationship (Type. Print) MATTHEW COHEN / BROTHER	11	POMONA S	OUTH, APT	. 8, BA	er, City or Town, State, . LTIMORE, MD	21208
altimore	t. Page rtment o rtant: If rjury or		20a. Method of Disposition 1	HEBREW	esition (Name of matory or other place! YOUNG MI	EN 04/2	6/2009	BALTIMORE	, MD
D D	permi Depar Impor any ir		23a. Part 1. Enter the disease, or complications that caused the deal		8900 REI:	STERSTOWN	ROAD -	NSON & BROS PIKESVILLE	, MD 21208
	Physician /Medical		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consec	01	25truct	ing, social as calculated	marura	Disease	Approximate Interval Between Onset and Death
	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	quence of):	Carch	i L Di	thy		
8/00,	ficate be executed physician and s the burial-transit	dical Exar	that initiated events resulting in death) Last C. Due to (or as a consected of the consec	quence of):	Dec	ma	740		
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as, r	uires that n signed b Id be deta	ρ	Part II. Other significant conditions contributing to death but not res	sulting in the u	nderlying cause giv	en in Part I.		obacco use contribute to ′es 2 □ No 3 □ P	o the cause of death?
i Records,	The law rec ate has bee page 2 shou	Completed						sy prior to death?	utopsy findings available completion of cause of
ı vital	ı ysician: iis certific director,	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2	ER/Outpatier	nt 3 □ DOA Oth	26. Place of Death		ne) dence 6 □Other (Spe	ecify)
IVISION OF	tending Pt eath. tor: After th the funeral	Certification: To	27. Manner of Death 1 Natural 5 Pending (Month, Day, Year) 2 Accident investigation 3 Suicide 6 Could not be	28b. Time of Injury	M 1□	Yes 2 □ No		now injury occurred	
	pital or At burs after d eral Direct filled in by		3 ☐ Suicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 5 ☐ Could flot be building, etc. (Special flot be building, etc.)				City or Tow		
	o the Hos vithin 24 ho o the Fundompletely	Medical	((Check only one) 2 Medical Examiner: On the basis of examin and manner stated.	ation and/or in	29c. Licens	opinion, death occur	red at the time,	date and place, and due	e to the cause(s)
),	->-0		30. Name and address of person who completed gause of death (Itel		Print)	1464		11291	05
4	7 √ Sta	te	SHOAIB A HAHMIMD, 82 31. Date filed (Month, Day, Year) 32. Registrar's Sign.	1 N. E	ENTAW	27 Sm	to 30 f	BALTIMO	NE MDZIZ
DHI	Registr IH 17 Rev 1/2		APR 2 7 2009 Server	A. A	arte				
					IGINAL				

09-03321 Mary L. Tumlin-Soto Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2009 13307

		- For State legistrar		Cer	tificate o	שם וו	aui					Reg. No.		1
Physicia edical Examir	n/	 Decedent's Name (First, Midd 	Mary L. Tumlin-Soto								Date of De Month April 25,	Day 2009	Year	3. Time of Death 1731 hrs
		4a. Facility Name (if not institution 1715 Patapsco Street	-	mber)			ty, Towr I ltim o r		cation of	Death		4c. (County of Dea N/A	l l
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la	ast birthday)		Jnder 1		If Under	24Hrs.	1		Fore	Birthplace (State or eign
Director	L	265-87-0825	1M_2_XF	45	Yr		onths	Days	Hours	IVIII.	02/08/	1964	(Country) Virginia
any	-	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Loca	ation								10d. Inside City Limits
and show	5	Maryland 1	V/A	Balt	timore									1 X Yes 2 No
Maryll	Director	10e. Street and Number	•			10f	. Zip Co					10g. Citizo	en of What Co	ountry?
vith the s 23a o e notifi		1444 Boyle Street	12. Was Dec	edent Ever in U.	S. 13. W	Vas De	2123 cedent o	of Hispa	anic Origi	n? (Spe	cify Yes or	No- 1	14. Race - Am	erican Indian, Black,
death v	Funeral	1 Never Married 2 X	1 103	orces? X No	If		,			Puerto F	Rican, etc.)		White, etc.	
5-0036 He within 72 hours after death with the Maryland ltygiene. other than "natural", or items 23a or 28a-f show any the Medical Examiner must be notified at once.	ᇍ	Widowed 4 Di 15. Decedent's Education (Spe	vorced If Yes, Give Yea or Dates:		16a. Decede		2 X			ind of wo	ork done		Specify: Wr ind of Busines	
72 hou n "nat al Exa	Completed	Elementary/Secondary (0-12			during	most o	f workin	g life. [OO NOT	use retire	ed)			C
0036 within giene. her tha	dwo	12 17. Father's Name (First, Middle	4		Proje	ect (boord			s Name ((First, Middle			on Company
21215-0036 uld be filed within 72 hours after Mental Hygiene. marked other than "natural", c event, the Medical Examiner.	BeC	James	, Last)		Tumlin			I	Brenda	1				Carson
O 용 등 호 글	리	19a. Informant's Name/Relation			1.5									ate, Zip Code)
and 2 stealth a traum	ł	James W. Soto- (20a. Method of Disposition			Place of Disp	osition	(Name			LUIIIO.	re, Mar Date	20c. L	ocation - City	or Town, State
altimore, mit Pages I ai partment of Hei portant: If ite	-	1 Burial 2 X Crematic			crematory or view Cre					04/3	0/09	Ba1	timore,	Maryland
Baltimore, ME permit Pages I and 2 s Department of Health an Important: If item 27 injury or other traum:	1	21. Signature of Funeral Service			22 Mr	Name	land Ac	dress o	f Facility	nera	1 Home,	P.A.	1 1 . 01.4	220
Physician	\dashv	23a. Part I. Enter the disease, o	r complications that of	caused the death	. Do not ente	r the m	ast 1	ying, s	uch as ca	ardiac or	respiratory	arrest, sho	land 212	Approximate Interval Between Onset and
/Medical xaminer	1 4	failure. List only one caus Immediate Cause (Final diseas	Dwanah	opneumo	nia									Death
Adminor		or condition resulting in death)	Due to (or as	a consequence o	of):									
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Caus		a consequence o	of):									
d sit	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to fee or	a consequence of	of):									
on of Vital Records, P.O. Box 68760, ending Physician: The law requires that the death certificate be executed rath. The trip is certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial - transit		X UNPENDED	dAMENDED	23a,27,	perME	G89	1 5	/15	/09 '	ГТ				
8760, tificate be execut ng physician and as the burial - trains	n/Medical	IF FEMALE:	23c. If yes,	outcome of pres	gnancy							230	d. Date of deli	-
c 687 certific ending use as t		23b. Was decedent pregnant in past 12 months?	4 Preg	birth nant at time of d		Fetal of Other	leath (Specif	3 L v)	Ectopi	c pregna	ncy		Month	Day Year
Box 687 he death certific the attending ped for use as the	Physicia	1 Yes 2 No 9 V U	0 01						ven in Pa	art I	23e. D	id tobacco	use contribute	e to the cause of death?
ires that the signed by the detached	by	Part II. Other significant cond	itions contributing	to death but not	resulting in th	ie unue	mymg c	ause g	Verriin					Probably 4 🗸 Unknown
ords, w require s been signer should b	ompleted	1									24a. W	/as an utopsy	prior	e autopsy findings available to completion of cause of
of Vital Records, ng Physician: The law requir Ufter this certificate has been s neral director, page 2 should I	omp											erformed? es 2 N	deat lo 1 ✔	h? Yes 2 No
Vital Rechysician: The this certificate	Be C	25. Was case referred to medi examiner?	Hospital:] =p(0)				of Death Other		only one) ig Home 5	Paside	ence 6 🗸 C	Other: Scene
n of Vil Jing Physic After this funeral dir	٢	1 Yes 2 No 27. Manner of Death		Inpatient 2 e of Injury th, Day,Year)	ER/Outpati 28b. Time			``	y at Worl				ury occurred	outer, doese
ion C tending eath or: Af the fun	ation		nding restigation	th, Day,Year)				1 Y	es 2	No				
Division pital or A tendir ours after death teral Director: A	Certification:	3 Suicide 6 Co	uld not be termined (Specify	ce of Injury - At	home, farm, s	street, f	actory, o	office b	uilding, e	tc.		on (Street a vn, State)	and Number o	r Rural Route Number, City
15 e 0 in		4 Homicide 29a. Certifier 1 Certifying	Physician: To the h	est of my knowle	dge, death o	ccurred	at the t	ime, da	te and pl	ace, and	due to the	cause(s) ar	nd manner as	stated.
Fo the Hos within 24 h Fo the Fur	Medical	one) 2 Medical E	caminer:On the basis and manner	s of examination	and/or invest	tigation	, in my o	pinion	death o	ccurred a	at the time, o	date and pla	ace, and due	to the cause(s) (Month, Day, Year)
	Ž	29b. Signature and title of cert	fier	1				O.C.I	e number M.E.			- 1	ril 26, 2009	
		30. Name and admess of pers	on who completed ca	use of death (Ite	m 23a)	-	_l							
Ø V		Pamela E. Southall,	MD Assistan	t Medical Ex	aminer	111 F	Penn S	Stree	t, Baltir	nore, l	MD 2120	1		
S Regis	tate trar	1002	7 2009 32.1	Registrar's Signa		ba.	41							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Trusty Carolyn Ann 04 16:20 ™ 19 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 5506 Wesley Ave Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min.) 06 27 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) Year) 50 **Funeral** Months 1 □ M 2 🔽 F 58 219-52-7553 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location Sources and Mental Hygiene.
Is man/ked other than "natural", or items 23a or 28a-f show raumatic event, I'm Medical Evonitar Lunst be notified at 1 Yes 2 No Director Baltimore MD NA10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21207 U.S.A. 5506 Wesley Ave by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after I Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify. Specify: Black 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Science Instruments Bench Worker 12th grade lyr 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mental permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic ev Grace Price Wilbert Trusty ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Md 21215 5513 Groveland Ave, Baltimore, Wilbert Trusty-Father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/24/09 Woodlawn, Md Woodlawn 22. Name and Address of Facility
March F/H West 21. Ignature of Fulheral Service Licenses Juna 4300 Wabash Ave, Baltimore, Md 21215 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imm Cause (Final disease or condition resulting in death) YOCARDIA **Physician** /Medical Die to for as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off: Examiner sician and burial-transit the death certificate be executed Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the for use . If yes, outcome of pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death
9 □ Unknown 23b. Was decedent preg 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 Other (specify) signed by the a P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 🗌 Yes 3 Probably 4 Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an page 2 autopsy 1 □Yes 2 No 25. Was a se referred to medica examiner? Be 26. Place of Death (Check only ope) Other: 4 Nursing Home 5 Desidence 6 Other (Specify) 1 Yes 2 🗌 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral (28a. Date of Injury (Month, Day, Year) 27. Ma er of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 1 / Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29b. Signature and title of certifier 30. Name and address of to completed cause of death (Item 23a) Type, State Registrar

Number **Funeral** 243-16-1785 Director Usual Residence of Decedent with the Maryland 10a. State Items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It. Wordical Exp. in a traut be notified as once. Director MD 10e. Street and Number Hayward Funeral 11. Marital Status Baltimore, Maryland 21215-0036 þ 3 Widowed 4 □ Divorced Completed Elementary/Secondary (0-12) 7th grade Be ပ 20a. Method of Disposition Sol Immediate Cause (Final **Physician** disease or condition resulting in death)

Physician

/Medical

Examiner

3627 Elizabeth Moses-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Marial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/28/09 Forest Lawn 22. Name and Address of Facility
March F/H West 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. End Stage Alzhumus
Due to (or as a consequence of): 1=nd Domentia /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) signed by the ☐Yes 2☐No P.0. g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð Completed 24a. Was an has e 2 s autopsy perform page certificate 1 □Yes Be 25. Was case referred to medical examiner? Hospital: 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of After 1 Natural 2 Accident 5 Pending investigation within 24 hours after usa...
To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 1445931 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend 10e, perFh 8891 5///09 TT& 19b
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Turnage Henry James 2009 10:55pm^M 04 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Pikesville er 1 Year | If Under 24 Hrs. Baltimore Milford Manor Nursing Home If Under Birthplace (State or Foreign Country) . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours Min 1 X M 2 □ F Yrs. 96 03 NC 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐Yes 2 ☐ No Baltimore NA 10f. Zip Code 10g. Citizen of What Country? 21215 U.S.A. -Ave 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes X☐ No Specify. Specify: Black 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Virginia Doughnut <u>Warehouse Worker</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Katie Bell Garfield Turnage 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3627 Haywood Ave, Baltimore, Md 21215 19a. Informant's Name/Relationship (Type. Print) 20c. Location - City or Town, State Richmond, VA 4300 Wabash Ave, Baltimore, Md 21215 Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No 26. Place of Death (Check only one) Other: 4 M Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) April 22 2001 2835 Smith Avenue Sufe 203 Baltimas MD DGbbie NIM 31. Date filed (Month, Day, Year) . Registrar's Sign Jure

Registrar DHMH 17 Rev 1/2001

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** MARY WINDSOR ANN 22 2009 /Medical or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner ALTIMORE WASHINGTON MEDICAL COYED If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number (In vrs last hirthday) 8. Date of Birth (Month, Day, **Funeral** Days Hours Min 1 M 2 K F 219-32-7467 April 12 1939 Pennsylvania **Director** Usual Residence of Decedent with the Maryland 10b. County show 10a. State 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, Ite Medical Examinar must be notified at Baltimore Maryland 1 4 1 N/A 1 XYes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21230 U.S.A. 1409 Riverside Avenue by Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐Yes 2 No White If Yes, Give Year or Dates 1 ☐Yes 2 No Specify: 3 ☐ Widowed 4 🕅 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Domino Sugar Company Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Mundy P. Sweeney Ann ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Windsor (Son) 4415 Sedgwick Road, Baltimore, Maryland 21210 Timothy 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Bavview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 04-23-09 Baltimore, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 130 East Fort Avenue, Baltimore, Maryland 21230 23a Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** mermith disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed To the Hospital or Attending Physician: The law requires that the death certificate be execut within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tran completely filled in by the funeral director, page 2 should be detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 No 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 🗌 No 3 ☐ Probably 4 ☐ Unknown Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) Inpatient 1 Tes 2 ER/Outpatient 3 DOA Certification: To 27. Man or of Death Date of Injury 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MD f person who completed cause of death (Item 23a) (Type, Print) 3th Heave two Glen Brine. mo. 206%.

State Registrar

Date filed (Month, Day,

Beneva S. San

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** MARIE WILLI Ams 10:08p 2009 /Medical 20 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2207 North Eutaw Place Apt 1 Baltimore If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Year) Months 1 M X F 263-30-4428 90 25 GA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD NA Baltimore 1X Yes 2 ☐ No 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? 2207 North Eutaw Place Apt 1 21217 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Bace - American Indian. Black, White, etc. 1 ☐ Yes 2√ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: Black \$ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 3rd Grade Lorien Nursing Home General Nurse Asst. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Loue Mathis INK NOW N 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Jamal Wilson-Grandson</u> 2207 North Eutaw Place Apt 1, Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State King Memorial Park 4/25/09 Woodlawn, Md 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, 21. Signature of Juneral Service Licensee Baltimore, Md 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MOUTE myochidin INFAPERION disease or condition resulting in death) Due to (or as a consequence of): THE TOSCHEDOTIC Equal tially liet or altrone, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) HYPER CHOLES POROLE Due to (or as a consequence of) Physician/Medical hod posty Dansio IF FEMALE: 23c. If yes, outcome of pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Year 4 ☐ Pregnant at time of death 5 Other (specify) □Yes 2 No 9 I Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 CADELNOWA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 👺 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 ☐ No 1 ☐Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2. No 1 TYes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

P.O. Box 68760.

e Hospital or Attending Physician; The law requires that the death certificate be executed 24 hours after death. • Funeral Director: After this certificate has been signed by the attending physician and attending physician for use as the buris signed by the at be detached f Division of Vital Records, director, filled in by the funeral

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant; If Item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, I'm Medical Examinar must be notified at

permit. Pages Department of Important; If Its any Injury or o

Physician

/Medical

Examiner

burial-tra

Baltimore, Maryland 21215-0036

Medical To the within 2 State Registrar

29b Signature and title of certifier

29c. License number D30408

WARHINGTON

BUND

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

> 29d. Date signed (Month, Day, Year) 11/77/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated,

VERT WINSTOW 100

31. Date filed (Month, Day, Year) 27

4 Homicide

(Check only

29a. Certifier

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Physician 4:55 P M 22 2009 April Frances Roggenkamp Yeager /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Gilchrist Hospice Towson Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 🛣 F 02/25/1949 Japan 60 Director 216-48-4525 Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County ortant: If Item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Miclical Examination rules be notified at 1 Tyes 2 TYNo Director Bel Air Harford 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21014 U.S.A. 1006 Wakely Circle Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2X Married Maryland 21215-0036 1 □Yes 2 No If Yes, Give Year or Dates: Specify. White Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important: If Item 27 is marked other the any Injury or other transmitted. Meat Wrapper Food/Grocery 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dorcas Thomas Joseph Roggenkamp 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1006 Wakely Circle, Bel Air, MD Robin Yeager/Husband Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ardent Cremation Services | 04/27/2009 | Hanover, Maryland Ardent Cremation Services 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 7522 Connelley Drive, Ste.N, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MONTAS **Physician** disease or condition resulting in death) MALIGNANT Due to (or as consequence of): /Medical Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed burial-tran and Due to (or as a consequence of) Box 68760, attending physician Physician/Medical the as IF FEMALE: use yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year ō Pregnant at time of death 5 Other (specify) signed by the a P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown cate has been si page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 1 ☐Yes 2 ☐No certificate 1 ☐Yes 2 No Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check onl one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSILE 1 Yes 2 No completely filled in by the funeral dire this Certification: To 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? To the Hospital or Attending F within 24 hours after death.

To the Funeral Director: After I 5 ☐ Pending investigation (Month, Day, Year) Injury 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide LX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DANIENE DOBERMAN, MO N CHAPLES ST, 8417-209 BALTIMONES MD 21204 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month Katharine LaRue Young 2009 April 23, 4:30 P 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not Institution, give street and number) CARROLL COUNTRY CARE FARM WESTMINSTER If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Min. Hours 1 □ M 2 🖫 F Months Days 87 220-01-4798 10/28/1921 MARYLAND Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐ Yes 2 XNo CARROLL WESTMINSTER 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 21157 1615 BOLLINGER RD. USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Specify: WHITE 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) STOCK CLERK MANUFACTURING 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ELIZABETH MARGARET BRADEN WALKING WILLIAM 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2234 KAUFFMAN RD., NEW WINDSOR, MD 21776 LINDA KAUFFMAN -DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) VIEW MEM. PARK 4/28/09 ELDERSBURG, MD LAKE 21. Signal of Coneral Service Licensee 22. Name and Address of Facility FLETCHER FUNERAL HOME, P.A. 254 E. MAIN ST., WESTMINSTER, Approximate Interval Between Onset and Death 23a. Part 1. Emer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caus Immediate Cause (Final disease or condition resulting in death) rears Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death?

Physician /Medical **Examiner**

physician and the burial-transit

attending pl

signed by the a

After this certificate has funeral director, page 2

I Director: /

within 24 hours a

To the Funeral I

completely filled filled

the Hospital or Attending Physician: The law requires that the death certificate be executed

Box 68760.

P.O.

Division of Vital Records,

Examine

Physician/Medical

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Certification: To

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Examiner

Funeral

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is 23a or 28a-f show

items

ir than "natural", or

7 is marked other traumatic event,

Department of Health as Important; if item 27 is any Injury or other trau

Director

Funeral

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filed within 72 hours after

Pages 1 and 2 should be nent of Health and Mental

Baltimore, Maryland 21215-0036

/Medical

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Lisease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

Mypercholosterolenia

2 No 1 □ Yes

24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No

25. Was case referred to medical examiner? 2 No 1 ☐ Yes

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of

26. Place of Death (Check only one)

Other: 4 □ Nursing Home 5 □ Residence 6 ② Other (Specify) SSISTED LIVING 28d. Describe how injury occurred

27. Manner of Death 2 Accident 3 ☐ Suicide

4 Homicide

5 ☐ Pending investigation 6 ☐ Could not be

determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number 00051924 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Herbert P. Henderxun Sr. Mp 297 3 Manche 31. Date filed (Month, Day, Year)

State Registrar



			For State Registrar	State of Marylan		rtment of F		Mental Hy	giene Reg. No. 2	109	13311
	Physicia /Medic			RL EDWARD Y	ODER			2. Date of De Month APRIL	23, 2		3. Time of Death $8:50 \ P^{M}$
*	Examin Funeral	er	4a. Facility Name (If not institution, give standard CARROLL HOSPITA 5. Social Security Number 6. Sex	L CENTER 7. Age (In yrs.		4b. City, Town, o WESTM If Under 1 Year Months Days	r Location of Dea INSTER If Under 24 Hrs Hours Min	8. Date of Bi	rth	Countr	
1	Director		183 – 18 – 5 4 3 1 Usual Residence of Decedent 10a. State 10b. County		37 Yrs.			12/26	5/1921	PENNS	SYLVANIA
filed within 70 house of an death with the Manager	s 23a or 28a-f show	Funeral Director	MD CARROT 10e. Street and Number 3 4 1 7 BUTTONWOOI 11. Marital Status 13			10f. Zip Code 21136		Specify Yes or N	10g. Citizen of USA	What Country	
	itural", or iten	þ	1 Never Married 2X Married 3 Widowed 4 Divorced 15. Decedent's Education	Armed Forces? 1ĂYes 2 □ No If Yes, Give Year or Dates: WWI	I 1	Vas Decedent of H i Yes, specify Cuba □Yes 2∑ No lent's Usual Occup	Specify:	rto Rican, etc.)	Speci	ack, White, etc	re Pe
of mithin 20	e d d	Completed	(Specify only highest grade Elementary/Secondary (0-12) 1 2 17. Father's Name (First, Middle, Last)	completed) College (1-4or 5+)	(Give I life. D	kind of work done of NOT use retired	during most of wo	_	MANUE	FACTUF	·
o should be fi		To Be		FRANKLIN YO		g Address (Street	VERN.	A A. TE	ROYER		Code)
ב ל ל	porning ranges rained by the part of the p		JULIA M. YODER 20a. Method of Disposition 1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify) 21. 4 Property of Funeral Survice Licensee	moval from State FAIF	Place of Dispos cemetery, crem	sition (Name of natory or other place UNION	CEM 4/	Date 27/09	20c. Location	- City or Tow	
) 1	hysician ohysician and husician and the prival-transit	dical Examiner	23a. Part 1 Enter the disease, or complic shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.		CION Puence of): FIBRI usres of): ENSION	NEUMONI	A	ac or respiratory a	arrest,	10	Approximate nterval Between Onset and Death
The law requires that the death certifica		Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of c	Ideath 3	Ectopic pregnanc Other (specify)	у			ate of delivery	y Day Year
odilizac that	been signed b	þ	Part II. Other significant conditions control DEMENTIA	ributing to death but not res	ulting in the un	derlying cause giv	en in Part I.		tobacco use cor Yes 2 ☐ No	ntribute to the 3 ☐ Probat	cause of death?
and off included and and and off	this certific al director, I	e Completed	25. Was case referred to medical				26 Place of De	24a. Was auto perfo 1 □ Yes eath (Check only	opsy ormed? 2,2 No	Were autops prior to comp death?	sy findings available pletion of cause of
		Certification: To Be	examiner? 1 Yes 22 No 27. Manner of Death 1 Natural 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day, Year)	ER/Outpatient 28b. Time of Injury	28c. Injur Worl	er: 4 🗆 Nursing	Home 5 ☐ Res 28d. Describe	idence 6 ☐ Ot how injury occu	rred	
	트를		4 Homicide determined 29a. Certifier 1 Certifying Physi	28e. Place of Injury - At he building, etc. (Specifican: To the best of my known: On the basis of examina	by) wiedge, death	occurred at the ti	me, date and pla	City or To	(Street and Num	nanner as sta	ited.
To the H	within 24 To the Fi	Medical	29b. Signature and title of certifier	and manner stated.		29c. Licens			,	ed (Month Da	
	Sta Registr		30. Name and address of person who com VALERIU CEBOTAR 31. Date filed (Month, Day, Year) APR 2 7 20	RU 200 32. Registrar's Signa	MEMO	Print) RIAL DR	., WEST	TMINSTE	R, MD	2115	7

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Gerald David Bitzel 2009 12:27a April /Medical **Examiner** 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore
9. Birthplace (State or Foreign Gilchrist Center for Hospice Care 'Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Country) Hours Months Days 1 ☑M 2 ☐ F 220-26-0401 Director 11/10/1931 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☐ No Director MD Baltimore Upperco 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 2801 Mt. Carmel Rd. 21155 USA Funeral 14. Race - American Indian, Black White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status DYes 2 No 1948-Yes, Give 1 ☐ Never Married 2 ☑ Married 1 ☐Yes 2 ☐No Specify: white <u>۾</u> 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) owner/operator real estate Bitzel & Associates 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Martin W. Bitzel Mildred Hunter ೭ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia M. Bitzel, wife 2801 Mt. Carmel Rd., Upperco, Md. 21155 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Carroll Cremation 4 ☐ Donation 5 ☐ Other (Specify) 4/14/2009 Hampstead, Md. 22. Name and Address of Facility Signature of Funeral Service Licenses M00741 Eline Funeral Home demmer Janka 934 S. Main St., Hampstead, Md. 21074 Approximate
Interval Between
Onset and Death
MM + 1 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performe 1 □Yes 2 ☑No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ospice 2 - No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

certificate be executed Box 68760 P.O. Records.

28a-f show

Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Midical Examment in 11st by notified at

within 72 hours after death

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Important: If It any injury or o

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signed by

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Maryland 21215-0036

Baltimore,

page 2 s has Division of Vital Pospital or Attending Pi 24 hours after death. Puneral Director: After t After filled in by the within 24 hours af

To the Funeral D

completely filled in To the WIL 10+12A

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles J. Balti mo 31. Date filed (Month, Day, 32. Redistrar's Signature Year)

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2009 **Physician** inter Janiece 11:49 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Arunde Medical Anne 4runde If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Min. 1 ☐ M 2 🔐 F Months Days Hours 14/200 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 28a-f show Department of Health and Mental Hygiene. Important; if Item 223a or 28a-f show important; if Item 27 is marked other than "natural", or items 23a or 28a-f show important; if Item 27 is marked other than must be refifted any Injury or other traumatic event, the Medical Execution investigation on 2000. Director othian 1 ☐ Yes 2 ☐ No Anne 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? USA 20711 am by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 🕍 no Specify Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jason Monica ပ Wayne 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1139 Sam Smith Ln. Lothian, Md. 20711 Tonica Smith 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD Atlantic Crematory 4/9/2009 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** eme PMaturitt /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) sician and burial-trans Due to (or as a consequence of): signed by the attending physician I be detached for use as the buria Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? ģ nis certificate has been s director, page 2 should 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □Yes 2 🗫 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Pinpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Matural 1 ☐Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Box 68760, P.0. Division of Vital Records,

Baltimore, Maryland 21215-0036

the Hospital or Attending Physiclan: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral

Medical State Registrar DHMH 17 Rev 1/2001

29b. Signature and title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

0021546

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

udkaff tam 2003 Medical

31. Date filed (Month, Day, Year) APR 10

29a. Certifier

(Check only one)

32. Registrar's Signature

			1 _ State		artment of Heal	th and Mental Hy	211119	1331	
			Registrar 1. Decedent's Name (First, Middle, Last)		timodic of Boo	2. Date of D		3. Time of Death	
	Physicia /Medic		Nancy L. Boyle			Month April	10, 2009 Year	2.123AM	
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Loca		4c. County of Death		
ad)			St. Catherine Nursing Center		Emmitsbu		Frederic		
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs 1 M 2 F 7.3	s. last birthday) Yrs.		ours Min. 8. Date of B (Month, D	Jay, Year) Countr		
			Usual Residence of Decedent				, 1935 Maryra	11IU	
	how how	_		City, Town or Lo			100	d. Inside City Limits	
	e Mar Ba-fs	Directo	Maryland Frederick E	Emmitsbu				1⊠Yes 2□No	
	hin 72 hours after death with the Maryland e. m. "natural", or items 23a or 28a-f show Midical Evan, incrinat by neithed at		10e. Street and Number 339 E. Main Street		10f. Zip Code 21727		10g. Citizen of What Countr	y?	
	death	Funeral	11. Marital Status 12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of Hispani	ic Orlgin? (Specify Yes or Nexican, Puerto Rican, etc.)			
30	hours after tural", or ite	by Fu	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes ☒️No	1		ecify:	Black, White, etc	_{c.} hite	
2-0036	thour		3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education		dent's Usual Occupation		 16b. Kind of Business/Indu	ustry	
212	within 72 iene. than "nai	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give life.	kind of work done during DO NOT use retired)	most of working			
7	wit the	Con	4	Teacl			Education		
and	be filed that Hygied of other event, I	Be	17. Father's Name (First, Middle, Last)		18. M	Mother's Name (First, Middl Sue Condon	e, Maiden Surname)		
\geq	d Mer marke matic	၀	Wilbur C. Le Gore 19a, Informant's Name/Relationship (Type. Print)	10h Maili	an Address (Street and N		ber, City or Town, State, Zip C	Codal	
Ma	id 2 si Ith an 27 is i		Patrick Boyle – husband	I		eet, Emmitsbu		21727	
<u>o</u>	s 1 an if Hea if tem 2				sition (Name of matory or other place)	Date	20c. Location - City or Tow	n, State	
altimor	Page:		1 M Burial 2 Li Cremation 3 Li Removal from State		rg Memorial	4-14-2009	Emmitsburg, Ma	aryland	
Salt	permit. Pages 1 and 2 should b Department of Health and Ment Important: If Item 27 is marked any injury or other traumatic e once.		21. Signature of Funeral Service Licensee		2. Name and Address of F		Funeral Home		
מ	g.∪ = # 0		A Sec. all I Sec.				ont, Maryland	21788	
		, 10	23a. Part 1. Enter the disease, or complications that caused the des shock, or heart failure. List only one cause on each line.	ath. Do not ent	ter the mode of dying, suc	ch as cardiac or respiratory	arrest,	Approximate Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death) a. All white the second						
	Examiner		Due to (or as a conse	quence of):	440	V	O	Wins	
		Jer	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	equence of):				3.0	
	ecuted nd ransit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events c.	iten	un			30-yrs	
Ď,	cate be executed physician and the burial-transit		resulting in death) Last Due to (or as a conse	quence of):				4	
08/PU	ficate be executed physician and s the burial-transit	dical	d						
XOX C	certifii nding p	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of preg				23d. Date of deliver	v	
-	death e atten d for u	sician/M	in the past 12 months?		☐ Ectopic pregnancy ☐ Other (specify)			Day Year	
л. Э	at the by the tache	Phys	9 Unknown						
33,	w requires that the death certifi been signed by the attending i should be detached for use as	by	Part II. Other significant conditions contributing to death but not re	sulting in the u	nderlying cause given in I		I tobacco use contribute to the Yes 2 ☐ No 3 ☐ Proba	e cause of death?	
Kecord	requipeen should	Completed						<u> </u>	
Ř	8 2 0	ldm				per	opsy prior to com death?	sy findings available pletion of cause of	
VITai	an: Th tificate or, pa	ပိ	25. Was case referred to medical		26	1 □ Yes	2 4No 1 □ Yes 2	! □ No	
>	ysicia is cert direct	To B	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 [☐ ER/Outpatie	Qui.		sidence 6 ☐ Other (Specify))	
ם פ	ng Ph fter th	J:T	27. Manner of Death 28a. Date of Injury (Month, Day, Year)	28b. Time o Injury			how injury occurred		
<u>0</u>	endir eath. or: Ai	catic	2 Accident investigation		M 1 ☐Yes	2 □No			
DIVISION	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At building, etc. (Spec	home, farm, str cify)	reet, factory, office	28f. Location City or To	(Street and Number or Rural own, State)	Route Number,	
ם .	spital ours a neral I		29a. Certifier Lectifying Physician: To the best of my ki	nowledge, deat	th occurred at the time, da	ate and place, and due to th	ne cause(s) and manner as sta	ated.	
	To the Hospital or Attending Physician: The In whin 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page:	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	nation and/or in	nvestigation, in my opinior	n, death occurred at the time	e, date and place, and due to t	the cause(s)	
_	Vithi Volume		29b. Signature and title of certifier	11	29c. License num	nber	29d. Date signed (Month, D.	ay, Year)	
				uou	10 010	0 (0)	7/10/0	1	
	12		30. Name and address of person who completed cause of death (Ite Alan Carroll, M.D., 310			mitsburg, MD	21727		
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Sign	nature 🥻	parle				
	Registr	ar	APR 13 2000 Deneus	1 19. 1					

DHMH 17 Rev 1/2001

Bittner

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Date of Death

8. Date of Birth (Month, Day, Year)

7,

31, 1942

April

Daisy Phillips

4/10/2009

Min.

2009

4c. County of Death

10g. Citizen of What Country?

United States

Specify:

16b. Kind of Business/Industry

20c. Location - City or Town, State

Martinsburg, WV

23d. Date of delivery

Month

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

14. Race - American Indian,

Beauty

Black, White, etc.

Frederick

3. Time of Death

12:52 P ^M

Birthplace (State or Foreign Country)

West Virginia

White

Approximate Interval Between Onset and Death

Year

10d. Inside City Limits

1X Yes 2 □ No

tensi

5 Pending investigation

6 ☐ Could not be

determined

1. Decedent's Name (First, Middle, Last)

Dorothy

Physician

/Medical

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 22No 1 □ Yes 2 No 26. Place of Death (Check only one) 28d. Describe how injury occurred

Hospital: Other: 4 Nursing Home 5 DR Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 1 ☐ Yes 2 ☐ No Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

21392

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PATRICIA KELLOG 1201 Seven Locks Rd. #111 Rockville, N

State Registrar

þ

Completed

Be

၉

Certification:

Medical

31. Date filed (Month, Day, Year) APR 13 2009

29b. Signature and title of certifier

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☐ No

27. Manner of Death

1 Natural 2 ☐ Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

32. Registrar's Signature

and manner stated.

W

DHMH 17 Rev 1/2001

reral Director:

within 24 hours a

Division of Vital Records,

09-03155 Christina Beach Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

Physician/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year 4.047 has		State of Maryland / Department - For State Certificate		e 2009 133
Chester (Wer Hospital Fig. 5). Seed Seed Seed Program of Seed Seed Seed Seed Seed Seed Seed See		Decedent's Name (First, Middle,Last)	ach April	Day Year 1317 hrs
216 - 88 - 2181 w 2 X 32		Chester River Hospital	Chestertown	Kent
To State Mod. Kent 10c. Copy, Town or Location 10d. 2g Code 10d. College of White Country 12 Yes 2 No. 10d. State and Number 10d. State and	ulleral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 3.2	Months Dave Hours Min	Foreign
The State and Number 1 of State and Number 2 of State and Number 2	au	10a. State 10b. County 10c. City, Town or L		i
More of Series 1	Maryland 28a-f sho d at once	1		
Anticinony Tytone Hawkins, Sr. Elina Mae Beach Anticinony Tytone Hawkins, Sr. Elina Mae Beach Anticinony Tytone Hawkins, Sr. Elina Mae Beach Anticinony Tytone Hawkins, Sr. Elina Mae Beach All Donatore Beach / Anticinony Medical All Donatore Beach / Anticinony State 20 Cenation 3 44 Theater In. Camden Dup De 19934 A Donatore Beach / Brown State 20 Cenation 3 Removal from State 20 Cenation 3 Removal from State 20 Cenation 3 Removal from State 20 Cenation 3 Removal from State 20 Cenation 3 Removal from State 20 Cenation 3 Removal from State 20 Cenation 3 Removal from State 20 Cenation 5 Other State 20 Cena	death with the lart items 23a or nust be notifie	11. Marital Status 12. Was Decedent Ever in U.S. 13 13. Never Married 2 Married Armed Forces?	Was Decedent of Hispanic Origin? (Specify Ye	es or No- etc.) 14. Race - American Indian, Black, White, etc.
Manage M	72 hours after n "natural", o al Examiner r eted by F	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Education (Specify only highest grade completed)	edent's Usual Occupation (Give kind of work don	ороспу.
Manage M	ed within lygiene. other than he Medic			
A District of Service Lorentee 22 Name and Address of Facility Young & McPherson F. H.	ould be fil. Mental H marked ic event, t			
The state of the s	s 1 and 2 sho of Health and If item 27 is ner fraumat	20a. Method of Disposition 20b. Place of Dis	sposition (Name of cemetery, Date or other place)	20c. Location - City or Town, State
The control of the c	permit. Page Department of Important: Injury or oth	4 Donation 5 Other Specify:		and the second of the second o
XUNPENDED AMENDED 23a,PII,27,28a-f,perME, g890 4/28/09 TT	/Medical xaminer	failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Oxycodone intoxical Due to (or as a consequence of): Sequentially list conditions,		Between Onset and
AMENDED 23, FIT1, 27, 28a-1, pet MLE, go y 4720 / U 1 FEMALE:	uted Id ransit I Examine	Couse Enter Underlying Couse (Disease or injury that initiated		
29b. Signature and title of certifier 29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) April 21, 2009	te be exec ysician ar burial - t		28a-f,perME, g890 4/28	
29b. Signature and title of certifier 29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) April 21, 2009	death certificat	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Pregnant at time of death 5		
29b. Signature and title of certifier 29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) April 21, 2009	signed by the be detached			
29b. Signature and title of certifier 29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) April 21, 2009	The law requirate has been bage 2 should	Obesity		autopsy prior to completion of cause of performed?
29b. Signature and title of certifier 29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) April 21, 2009	Physician: rr this certifical director, p	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpa	other 3 DOA Other Nursing Home	e 5 Residence 6 Other:
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) April 21, 2009 30. Name and address of person who completed cause of death (Item 23a)	r Attending ter death. irector: Afte n by the fune fication:	Natural 5 Pending (Month, Day, Year) Fd 4/20/09 Fd 9 Accident Investigation 28e. Place of Injury - At home, farm,	o:00 am 1 Yes 2 X No un	k
29b. Signature and title of certifier 29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) April 21, 2009	e Hospital c 24 hours af e Funeral D letely filled i	4 Homicide determined (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	occurred at the time, date and place, and due to	the cause(s) and manner as stated.
	To th withir To th compl	and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	'	30. Name and address of person who completed cause of death (Item 23a)	nn Street, Baltimore, MD 21201	

OCME

Physician
/Medical
Examiner

Funeral

Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Enviring must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Sta Regist

State of Maryland / Department of Health and Mental Hygiene 1 - State State Registrar Certificate of Death Reg. No. 2009 1332										
	1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death					
ian cal	Nelly Azucena Bajana Buzetta			2009 Year	10:50 AM					
ner	4a. Facility Name (If not institution, give street and number) 7 Kenton Court	4b. City, Town, or Location of Silver Spring		4c. County of Death Montgomery						
Г	5. Social Security Number 6. Sex 7. Age (<i>In yrs. last birthda</i> 577–66–6711 1 M 2 F 78 Yrs.	Months Days Hours	4 Hrs. 8. Date of Birth Min. Month, Day, Yea May 2, 19	9. Birtl Co. FC118	nplace (State or Foreign untry) BOOL					
	Usual Residence of Decedent	sual Residence of Decedent								
-o	10a. State 10b. County 10c. City, Town or MD Montgomery Silver S		10d. Inside City Limits 1 □ Yes 2 No							
ect	MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What C									
al Dii	7 Kenton Court	20902								
-nner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No	Was Decedent of Hispanic Origi If Yes, specify Cuban, Mexican,	14. Race - Ame Black, White							
d by F	3 M Widowed 4 □ Divorced Sive Year or Dates:	1 ☐Yes 2 ☐ No Specify:	Ecuadorian	Specify: Wh	ite					
Completed by Funeral Director	(Specify only highest grade completed) (Gi	cedent's Usual Occupation ive kind of work done during most o e. DO NOT use retired)	of working 16b.	Kind of Business/I	ndustry					
mo	Elementary/Secondary (0-12) College (1-4or 5+) 4 Exec	cutive Administra	ative Asst. I	nternatio	onal Finance					
Be	17. Father's Name (First, Middle, Last)		s Name (First, Middle, Maide	· · · · · · · · · · · · · · · · · · ·						
ဥ	Juan Emilio Bajana 19a. Informant's Name/Relationship (Type. Print) 19b. Ma	ailing Address (Street and Number	a Rosa Buzett		(in Code)					
		Kenton Court Silv			.p code)					
	1 Li Buriai 2 Ly Cremation 3 Li Removal from State 1	sposition (Name of rematory or other place)		Location - City or						
	4 Donation 5 Other (Specify) W. Arundel Crematory 04/11/09 Odenton, MD 21. Signature of Funeral Service Licensee Coing Home Cremation Service P.O. Box 784									
	Beverly L. Heckrotte, P.A. Clarksville, MD 21029									
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pospinatory Failure)									
	Immediate Cause (Final disease or condition resulting in death) Respiratory Fail Due to (or as a consequence of):									
-	Lung Cancer									
dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.									
al Exe	resulting in death) Last Due to (or as a consequence of):									
	d									
Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Use 3 a May 2 Fetal death 3 Ectopic pregnancy 23d. Date of company 23d. Date of compa									
hysic	1 ☐ Yes 2 🖾 No 4 ☐ Pregnant at time of death 9 ☐ Unknown		Day Year							
by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to									
eted			obably 4 Unknown							
Completed by		death?	topsy findings available completion of cause of							
Be (25. Was case referred to medical examiner?		of Death (Check only one)							
2										
ation	27. Manner of Death 1 ♠ Natural 5 □ Pending 2 □ Accident investigation 28a. Date of Injury (Month, Day, Year) 28b. Time Injur		ury occurred							
rtific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street : City or Town, Sta	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
a Ce	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
Medical Certification: To	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (and manner stated). 29b. Signature and title of Dertifier 29c. License number 29d. Date signed (Month, Day, Year)									
	250. Signature and the order men	29d. License number 29d. Date signed (Month, Day, Yea April 10, 2009								
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)									
	Vinni Juneja, M.D. 6420 Rockledge Drive Suite 4100 Bethesda, MD 20817									
ate rar	31. Date filed (Month Day, Year) APR 1 4 2009 Sense 5.	barles								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No.2009 3321 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) BRUNO Month Vear 51308M JOYCE GOULD pril 2009 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Howard County General Hospital Columbia Howard If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign Country) West Virginia 8. Date of Birth (Month, Day, Yea 3/24/1928 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Days 1 □ M 2 1 F 81 Yrs 136-24-2539 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 □ Yes 2XXNo Director MD Ellicott City Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9610 Splendid View 21042 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 If Yes, Give Year or Dates: **2XX**No 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 XNo Specify. 2 3 □Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Delcie Chewning Wilson Curtis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Z. Shell / Daughter 9610 Splendid View, Ellicott City, MD 21042 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 ☐ Burial 2 Cremation 3 Removal from State Ardent Cremation, Inc. 4/13/2009 | Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH, Inc. M01411 4112 Old Columbia Pike, Ellicott City, MD 21043 23a. Part 1. Enter he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final rascular occident Cerebral Day disease or condition resulting in death) Due to (or as a consequence of): Diabetes eavs Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hypertension years Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 XN 1 ☐ Yes 2 ☐ No 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 K ER/Outpatient 3 ☐ DOA Certification: To

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit P.O. Box 68760, Division of Vital Records,

Physician

/Medical

Examiner

Funeral

Director

show

Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

Department of F Important; If ite any injury or ott once.

Physician

/Medical

al Hygiene.

Pages 1 and 2 should be filed within 72 hours after death with the

Baltimore, Maryland 21215-0036

28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 🗆 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number D0063303

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MO

5755 Cedar Lane, Columbia MQ 21049

State Registrar

Medical

KODILA 31. Date filed (Mor

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** April 20 Day 2009 Year 8:18 A M Agnes T. Brown /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice Care Towson Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/10/1925 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🖾 F 83 Director 219-22-9149 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show er than "natural", or items 23a or 28a-f sho 1 XYes 2 ☐ No Director MD Harford Aberdeen 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 365 James Ave. 21001 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black. White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify Specify Black ş 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, Item Many injury or other traumatic event in the Many injury or other traumatic event in the Many injury lementary/Secondary (0-12) College (1-4or 5+) Clerk/typist Civil Service 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Griffin Mary Askins ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Aberdeen, MD Vernon W. Brown, Sr. (Spouse) 365 James Ave. 21001 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4/25/09 Union United Meth Cent. 4 ☐ Donation 5 ☐ Other (Specify) Aberdeen, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 Tarring—Cargo Funeral Home Aberdeen, Maryland 21001—23a. Part1. Enter the disease, or compilations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final OF ESOPHABLAL CANCER **Physician** COMPLICATIONS disease or condition resulting in death) Months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by Sepsis provnonin due to esophageal 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy 1 □Yes 2 □No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other (Specify) WSOLO Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide 29a. Certifier 🚝 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year) and title of certifier 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N Towson MO W 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Francis Billotti-Wood 13323 2009 1- For State Certificate of Death Reg. No Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day April 18, 2009 Francie Lyn Billotti-Wood 0925 hrs **Medical Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Frederick Middletown 13 Washington Street 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** cMannyland Months Davs Hours Min. 212-86-2217 1976 Feb. 27, Director 1 M 2 X F Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Middletown 1X Yes 2 No Frederick Maryland or 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryland near of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21769 U.S.A. 13 Washington Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, Funeral 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces 1 Never Married 2 Married Yes 2 X No Specify: White Yes 2X No specify: 3 X Widowed Yes, Give Year Divorced ģ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Non-Profit Organizations Fund Development Baltimore, MD 21215-0036 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Frances Warnick Sam Billotti III Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4952 Flossie Ave., Frederick, MD 21703 Sam Billotti III, Father 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation Removal from State Zion Lutheran Cemetery Apr. 24, 2009 3 Middletown, MD Department of Important: injury or otl Other Speqify Donation 5 22.NKeeney and Basford PA Funeral Home 21. Sign the e of tuneral Service Li 106 East Church St., Frederick, MD 21701 M00255 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line /Medical Death Junshot Wounds (2) of Head Immediate Cause (Final disease **xaminer** or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of). events resulting in death) Last signed by the attending physician and be detached for use as the burial - transit requires that the death certificate be executed Physician/Medical UNPENDED **AMENDED** Box 68760 23d. Date of delivery IF FEMALE 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Year Live birth Month Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 ✔ Unknown 9 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown þ Completed 24b. Were autopsy findings available 24a. Was ar autopsy prior to completion of cause of The law certificate has death? performed? 1 🗸 Yes Yes 2 the Hospital or Attending Physician: 'hin 24 hours after death.
the Fumeral Director: After this certifinpletely filled in by the funeral director, I 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? DOA Nursing Home 5 Residence 6 ✓ Other: Scene Inpatient 2 ER/Outpatient 3 1 V Yes ٩ 28a. Date of Injury (Month, Day, Year) FOUND: 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work 27. Manner of Death Certification: Subject shot FOUND: Natural Pending Yes 2 V No Apr 18, 2009 0909 hrs 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State)
13 Washington Street, Middletown, MD within 24 hours at To the Funeral D (Specify) Single Family 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 2 1 and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number April 19, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a)

State Registrar

32 Registrar's Signature 31. Date filed (Month, Day, Year)

OCME

Donna M. Vincenti, MD

Assistant Medical Examiner

ORIGINAL

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** CORE Month 4 720 M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 84 4th Street Lothian Anne Arundel Social Security Number | If Under 1 Year | If Under 24 Hrs. | | Months Days Hours Min. | 6. Sex 8. Date of Birth (Month, Day, Year) 2/27/1957 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 □ M 2 🗷 F 220-66-8312 Yrs. **Director** 52 Washington, DC Usual Residence of Decedent filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other fraumatic event, the Medical Examination 1 and 100ce. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Anne Arundel Funeral Director Lothian 1 ☐ Yes XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 84 4th Street 20711 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 δ If Yes Give 1 ☐ Yes 2 ☑ No Specify. White 3 Widowed 41 Divorced Specify: Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Cashier Retail 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) James F. Lore Sue Owen Waters 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jack Moore Friend 84 4th Street Lothian, MD 20711 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Atlantic Crematory 4/9/2009 Glen Burnie, MD 4 Donation 5 Dother (Specify) 73: 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral 39 vice Licensee 12 Ridgely Ave. Annapolis, MD 21401 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition Due to (or a a consi quence of): /Medical resulting in death) Examiner w Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Physician: The law requires that the death certificate be executed transit-Examin physician a s the burial-1 Due to (or as a consequence of) Box 68760, Physician/Medical attending pl IF FEMALE: 23b. Was decedent pregnant yes, outcome of pregnancy 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 5 ☐ Other (specify) P.0. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Records, ð has been si e 2 should 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page certificate Division of Vital 1 ☐ Yes 2 Ø No 1 ☐ Yes 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes this ٩ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After thi funeral of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: or Attending 1 Natural 5 ☐ Pending To the Hospital or Attendir within 24 hours after death. To the Funeral Director: A completely filled in by the ft. death. 2 Accident investigation 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, Cify or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated.

State

31. Date filed (Month, Day, Year)

APR 10

29b. Signature and title of certified

who completed cause of death (Item 23a) (Type, Print)

La VEN M M N 444 DEFENSE HIGHWAY ANAFOY

21438

29d/pate signed (Month, Day, Year)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Mary		ertificate of		Reg.		13325		
I	Physici	an	1. Decedent's Name (First, Middle, La					2. Date of Death		3. Time of Death		
	/Medic	cal	Paul Bancroft Cl 4a. Facility Name (If not institution, given			4b. City Town o	or Location of Death	4	9 2009 4c. County of Death	7:22 P M		
4	Examili	lei	1574 Teal Dr.			0cean	City		Worcester			
	Funeral Director		5. Social Security Number 6. S 032-26-0633 Usual Residence of Decedent	Sex 7. Age (In 78 78 78	yrs. last birthday Yrs.	Months Days		8. Date of Birth (Month, Day, Ye 2/24/193	9. Birth Cou	hplace (State or Foreign untry) MA		
	yland Iow		10a. State 10b. County			10d. Inside City Limits						
	e Mar	ctor	MD Worcest	er	Ocean C	ity			1 X □Yes			
	ath with th 23a or 20 ust be no	Funeral Director	10e. Street and Number 1574 Teal Dr.			10f. Zip Code 2184	2	10g.	Citizen of What Cou USA	intry?		
2-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, its Modical Evenine must be notified at once.	þ	11. Marital Status 1 □ Never Married 2\(\) Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates:	in U.S. 13	. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 🖔 No	Hispanic Origin? (Specan, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: Wh			
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yland	ould b Ment narked	2	Dr. Stewart H. C					Burnett				
Z	nd 2 sh alth and 27 is n ir traun		19a. Informant's Name/Relationship (Carol Clifford /				t and Number or Rura ••• Ocean (ip Code)		
ore,	ges 1 and 2 at of Health a lf item 27 is or other trau		20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐			osition (Name of ematory or other pla lopen Cre		- 1	. Location - City or T			
Бащтог	nit. Pag artmen ortant: Injury		4 ☐ Donation 5 ☐ Other (Special 21. Signature of Fundal Service Licer		rankford,	DE						
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			23a. Part 1. Enter the disease or com shock, or Heart failure. List only	plications that caused the cone cause on each line.						Approximate Interval Between		
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	ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cor	nsequence of):	Ha-	+ 15	luce				
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Š	certific Iding p		IF FEMALE:	23c. If yes, outcome of pro	egnancy	·						
.0.	To the Hospital or Attending Physician: The law requires that the death cenwithin 24 hours after death. To the Luneral Director: After this certificate has been signed by the attendit completely filled in by the funeral director, page 2 should be detached for use	Physician/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birth 2 4 Pregnant at time	Fetal death 3	☐ Ectopic pregnand ☐ Other (specify) _	су		23d. Date of deli	very Day Year		
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coras,	ding Phystcian: The law require h. Affer this certificate has been si funeral director, page 2 should t	Completed						24a. Was an	24b. Were aut	opsy findings available		
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. Te	slcian: certifii rector,	Be	25. Was case referred to medical examiner?	Hospital:		Oth	26. Place of Death					
5	g Physical dispersal di	n: 7	1 ☐ Yes 2 ☐ Alo 27. Manner of Death	1 ∐ Inpatient : 28a. Date of Injury (Month, Day, Yea	2 ER/Outpatie	of 28c. Inju	rv at 2	ne 5 Residence 28d. Describe how in	e 6 ☐ Other (Special of the first of the fi	ify)		
5	tendin eath. or: Aft the fur	catio	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be				Yes 2□No					
2	tal or Attend s after death al Director: , ed in by the f	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Sp.	At home, farm, st pecify)	reet, factory, office	2	28f. Location (Street City or Town, St	and Number or Rui ate)	al Route Number,		
:	n 24 hour	Medical	29a. Certifier (Check only one) (Check only one)	nysician: To the best of my niner: On the basis of exam and manner stated.	knowledge, dea mination and/or i	th occurred at the ti nvestigation, in my	ime, date and place, opinion, death occurr	and due to the caus ed at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)		
	To the To the comp	M	29b Signature and title of certifier	7	1,	29c. Licens	se number	29d.	Date signed (Month	, Day, Year)		
			JAM IN	Um Dergn	null	Dulina)	64645		1/10/09			
É	3A 20H		36 Name and address of person who	Begmuelle	(item 23a) (Type	Coasta	Hospice	PG BOX	(733 Sa	Isburmo		
	Sta Registra		31. Date filed (Month, Day, Year) APR 1 3 20	32. Registrar's S	A. A.	ake						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day \mathbf{A}^{M} 8, 2009 Mary C. Curtis April 7:30 /Medical 4a. Facilify Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 1907 Red Oak Drive Adelphi Prince George's If Under 24 Hrs. 8. Date of Birth (Month, Day, Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 🗓 F Director 579-40-5332 Oct. 8. 1932 Washington, DC Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show ed other than "natural", or items 23a or 28a-f showere, the Mcdical Evantinar must be notified at Director XXYes 2 No MD Prince George's Adelphi 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1907 Red Oak Drive 20783 United States Pages 1 and 2 should be filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No à Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) of Health and Mental Hygiene.
Item 27 is marked other than other traumatic event College (1-4or 5+) <u>Secretary</u> Pepco 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Raymond Harrell ဂ္ဂ Beatrice Harhin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert L. Curtis, Sr. (spouse) | 1907 Red Oak Dr. Adelphi, MD 20783 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Fort Lincoln Cemetery 4/13/2009 | Brentwood, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Road Brentwood, MD 20722 uhard hompso it 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Lung Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ۾ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📉 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an director, page 2 s performed' 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After thi funeral of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation I Director: Aid in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide To the Hospital within 24 hours a To the Funeral D 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D002325 4/10/05 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (3) 6502 Kenilworth Ave. Riverdale, MD 20737 Madhu K. Mohan, M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State APH 1 4 ZUUS Registrar

	Baltimore, Maryland 21215-0036
Phy /N Exa	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
/sid led am	Department of realth and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
cia iic in	any Injury or other traumatic event the Martine Feet sites and the confined at

Division of Vital Records, P.O. Box 68760,

		1 - State Registrar	Cer	tificate of E	Death	Reg. No. 2003 13321							
Physici /Medic		Decedent's Name (First, Middle, Last) James Michael Coffey				2. Date of De Month	Day	Year 2009	3. Time of Death /520 M				
Examin		4a. Facility Name (If not institution, give street and number) Part I Suum Region to Medical		4b. City, Town, or I	. ' 	4c. County of Death Wicemico							
uneral irector		5. Social Security Number 6. Sex 7 7. Age (In 098–34–4483 1 M 2 □ F 65 Usual Residence of Decedent	yrs. last birthday) _ Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir Month, Da 11/20/	1943	9. Birthpli Count New	ace (State or Foreign ry) York				
Ba-f show tiffud at	Director		City, Town or Loc Wilming	ton					d. Inside City Limits 1 Yes 2 No				
23a or 2 st by is		10e. Street and Number 3082 New Castle Ave		10f. Zip Code 1972	.0		10g. Citizen USA	of What Count	ry?				
Important: If them Z7 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it is Medical Examination into the indifferent once.	To Be Completed by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever Armed Forces? 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	in U.S. 13. Was Decedent of Hispanic Origin? (Specifyes, specify Cuban, Mexican, Puerto R 1 □ Yes 2 No Specify:			pecify Yes or No Rican, etc.)		Race - America Black, White, e ecify: whi	tc.				
han "natur e Medical		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give k	ent's Usual Occupa kind of work done do OO NOT use retired)	uring most of worl	king		f Business/Ind	,				
ther t		12 –	serv	ice/maint	.enance 18. Mother's Nam	ne (First, Middle	-	ting co name)	ompany				
rked o		John W. Coffey			Kathl	een Mor	an						
27 is mai er traumat		19a. Informant's Name/Relationship (Type. Print) Daniel L. Coffey/son		g Address (Street a 5 Lincoln					Code)				
ant: If item any or oth		1 Buriai 2 Li Cremation 3 Hemovai from State	alisbury Crematory Date 20c. Location - City or T 4/6/09 Salisbury,										
Importa any Inju	1	22. Name and Address of Facility Holl Toway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804											
sician edical iminer	sal Examiner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. 5 mol/ 6/1 Undifferentiated Carainana Due to (or as a consequence of):											
attending physician and for use as the burial-transit		Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d											
y the attending ph ched for use as th	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Fetal death 3	etal death 3 Ectopic pregnancy				Date of delive Month	ry Day Year				
signed b	d by Pr	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I. 15e. 25e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.											
After this certificate has been signed by the funeral director, page 2 should be detached	Completed by	Enghysen Prev Trectnest-induced Po	moris	enic		24a. Was auto perio 1 🗆 Yes	psy ormed?	4b. Were autop prior to con death? 1 ∐Yes	osy findings available inpletion of cause of				
certif	Be	25. Was case referred to medical examiner?		1 Oth -	26. Place of Dea								
After this funeral di	ertification: To	27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	2 ER/Outpatient 28b. Time of Injury	28c. Injury Work	4 □ Nursing H	ome 5 ☐ Res 28d. Describe			"				
To the Funeral Director: completely filled in by the	Certifica	3 Suicide 6 Could not be determined 28e. Place of Injury-building, etc. (S	At home, farm, stre	eet, factory, office			ation (Street and Number or Rural Route Number, y or Town, State)						
te Funera	edical C	29a. Certifier (Check only one) 1 CertifyIng Physician: To the best of m 2 Medical Examiner: On the basis of examiner and manner stated.	y knowledge, death amination and/or inv	occurred at the time vestigation, in my op	ne, date and place pinion, death occu	e, and due to the urred at the time	e cause(s) and , date and pla	d manner as st ce, and due to	ated. the cause(s)				
2	Me	29b. Signature and title of certifier	<i>7</i> .	29c. License	069 ₀			gned (Month, L					
M		30. Name and address of person who completed cause of death	(Item 23a) (Type, F	Print) MD 318	801								
Sta Registi		31. Date filed (Month, Pay, Year) 32. Registrar's 3	1.5 bury Signature	have									

State of Maryland / Department of Health and Mental Hygiene ? 13328 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death APRIL 19 2009 ear **Physician** 5:40A M MILDRED CAVADA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner CHARLES CO.NURSING & REHAB. LA PLATA CHARLES If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) MAY 7, 1913 9. Birthplace (State or Foreign Country)
PA **Funeral** 1□M 2♥F Months Days Hours Min 95 Yrs. 185-22-7910 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits r than "naturel", or Iteme 23a or 28a-f ehow The Medical Examinar must be notified at LA PLATA 1 XYes 2 No CHARLES Director MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20646 U.S.A. 10200 LA PLATA ROAD Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE 3√ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. OWN HOME HOMEMAKER and Mental Hygier 12 nt of Health and Mental Hygi : if item 27 le marked other or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be ANDREW KRAMER KATHERINE SKRISO ဨ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOYCE GENTILO-DAUGHTER 3255 TWINBREAK DR. WALDORF, MD. 20603 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State TWIN VALLEY MEM. PARK 4-23-09 DELMONT, PA X Burial 2 Cremation 3 Removal from State Department of Importent: if eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
RAYMOND FUNERAL SERVICE, P.A.
LA PLATA, MARYLAND 20646 21. Signature of Furleral Service Licensee. M00479 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death binatory Tailure Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐ Pregnant at time of death 5 Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ old age 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Hospital or Attending Physician: after death.

Director: After this certific in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No ဥ 27. Manner of Death 28c. Injury at Work? Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation Injury 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a

To the Funeral C

completely filled i 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier ş 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10061652 leted cause of death (Item 23a) (Type, Print) 11350 Penbrooke Sq. Waldert, md. KA TU MD 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death ONNER **Physician** 0521 M /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death IS. MANDARIN HOUSE HARWOOD ANNE ARUNDEL ROAD 5. Social Security Number (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11-29-1930 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 1 M 2 F 220-28-7028 78 WASH., D.C. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or "0" any injury or other traumatic event. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD. PRINCE GEORGES ACCOKEEK 1 ☐ Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15200 EAST AUBURN ROAD 20607 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No δ Specify: Specify: WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER 12 OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be FRANK A. ROBINSON ELIZABETH BOURNE ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TIMOTHY J.CONNER, SR. SPOUSE 15200 EAST AUBURN RD. ACCOKEEK, MD. 20607 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Magazial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ST.PAUL'S CEMETERY 4-21-09 BADEN, MD. 22. Name and Address of Facility
RAYMOND FUNERAL SERVICE, P.A. 21. Signature of Funeral Service Licensee M00479 LA PLATA, MD. 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwood Onset and De Immediate Cause (Final METASTATIC **Physician** NUNI (DEL disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of). the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 5 ☐ Other (specify) the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown cate has been a page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform rmed? 2 No this certificate 2 🗆 No 1 ☐ Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 417) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 177)50166 27. Manper of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After toust 1 Natural 5 Pending investigation 2 Accident s after death.

I Director: A in by the fu death. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours aft

To the Funeral Di

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

ORIGINAL

cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Year **Physician** 1901 , Jae Renee 4 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Chestertown MD Kent Hospital Chester River If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 1 F Months Days 4/17/09 N/A 19 MD **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c, City. Town or Location 10d. Inside City Limits ir than "natural", or Items 23a or 28a-f show the Wedical Eventine must be notified at QUEEN ANNE'S 1 XYes 2 No Director MD GRASONVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5122 MAIN ST. APT. 1 21638 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □ Yes 2 🛣 No Specify: BLACK Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 0 N/A17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental H Important: If item 27 is marked oth any Injury or other traumatic even once. Pages 1 and 2 should be UNKNOWN KIRA R. WOODUS 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KIRA R. WOODUS/MOTHER 5122 MAIN ST. APT. 1 GRASONVILLE, MD 21638 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION 4/20/09 STEVENSVILLE, MD 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME
130 SPEER RD. CHESTERTOWN, MD 21620 21. Signature of Funeral Service License 23a. Part 1. Enter the di eas , or com shock, or heart failure List only or complications that c th death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Severe METABOLIC +Cidosid /Medical Ity povolenia **Examiner** Known Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Promaturity 022 weeks Examiner Physician: The law requires that the death certificate be executed Dovo(physician and s the burial-trans Due to (or as a consequence of): Box 68760. Physician/Medical 113 CE IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.O. 09 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown A cle 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate 2 🗆 No 1 ☐ Yes 2 **N**0 1 Tes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Mnpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Accident 5 Pending 1 ☐ Yes 2 ☐ No filled in by the fi investigation 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral C 29a. Certifier 🗗 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State

Registrar

29b Signature and title of pertifier

Julio Ramirez MD

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

3645

29d. Date signed (Month. Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Gertrude Disharoon 2009 9:20 A M 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death S DUC 4 If Under 24 Hrs. oasta omico 8. Date of Birth (Month, Day, Year) 09/06/1911 Social Security Number Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Months 1 □ M 2 🛛 F 97 214-10-7169 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 XYes 2 No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 827 Eastern Shore Dr. 21804 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify white Specify: 3₺ Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) presser shirt factory 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Minos Phippin Viola Hearn 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Scott/daughter 106 Ironshire St., Snow Hill, MD 21863 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Parsons Cemetery 4 Donation 5 Dother (Specify) 4/8/09 Salisbury, MD 21. Signature of Funeral Section Licensee Name and Address of Facility
Holloway Funeral Home Professional Association CFSP 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) rage Due to (or as a consequence of): tensic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably → Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed

1 ☐ Yes

26. Place of Death (Check only one)

2 No

Other: 4 Nursing Home 5 Residence Seather (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

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Completed

Be

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Internet, or items 23a or 28a-f show Important: If the Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Madical Examine. The state of the contract of th

コピート しょりん この Baltimore, Maryland 21215-0036

burial-transi and attending physician the as use ō signed by the a d be detached f page 2 should has

Box 68760

P.O.

Records,

Division of Vital

Examiner Physician/Medical þ Completed

Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. After this certificate funeral (

Certification: To in 24 hours and the Line of the Funeral Director: Af moletely filled in by the fu

25. Was case referred to medical

5 Pending

rum

investigation

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 Could not be determined

1 Tes 2 No

examiner'

27. Manner of Death

1 Natural

2 Accident

4 Homicide

(Check only one)

31. Date filed (Month. Day

29b. Signature and title of certifier

3 Suicide

29a. Certifier

completely To the I 10

the

DHMH 17 Rev 1/2001

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1 ☐ Yes 2 ☐ No

28a. Date of Injury (Month, Day, Year)

Certificate of Death

4b, City, Town, or Location of Death

2. Date of Death

2,

2009

USA

4/3/2009

21851.

Month

April

Snow Hill

If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Months 1 M 2 X F 214-10-8724 91 Director Oct. 2, 1917 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10b. County 28a-f show Examiner must be notified Snow Hill Directo Maryland Worcester 10e. Street and Number 10f. Zip Code ō 21863 6625 Whitesburg Road "natural", or items 23a by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iten any Injury or other traumatic event, the Medical Examinar 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) housewife 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Alice Dukes Ernest Garrison Workman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3142 Johnson Rd., Pocomoke City, MD 21851 Peggy D. Johnson/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Oak Hall Riverside
Cemetery Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/5/09 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Name and Address of Facility
Holloway Funeral Home Professional Association
501 Snow Hill Rd., Salisbury, MD 21804 Javid H. CFSP Compson 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ALZHEIMER'S DEMENTIA **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the attending physician and hed for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 ☐ Ectopic pregnancy 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed autopsy performed 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury 5 ☐ Pending investigation (Month, Day Year) To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: At completely filled in by the fu 1 Yes 2 No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide determined 1 Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of centimer

MD

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SATYAL, MD

1. Decedent's Name (First, Middle, Last)

LILLIAN DENNIS

4a. Facility Name (If not institution, give street and number)

Marilyn Home for the Aged

Physician

/Medical

Examiner

9:25 a M 4c. County of Death Worcester 9. Birthplace (State or Foreign Maryland 10d. Inside City Limits 1 ☐ Yes 2X No 10g. Citizen of What Country? 14. Race - American Indian, white 16b. Kind of Business/Industry domestic 20c. Location - City or Town, State Libertytown, MD Approximate Interval Between Onset and Death 23d. Date of delivery Month 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ 100 2 10 No ASSISTED LIVING 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Registrar DHMH 17 Rev 1/2001

State

D0062172

1604 MARKET ST POLOMOKE CITY MD

State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Habbart Dean 12:55A 0 2009 APRIL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** WORCESTER BERLIN NURSING & REHAB CENTER BERLIN If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Months 1**X** M 2□ F 215-20-1991 82 Director 04/19/1926 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County 28a-f show traumatic event, the Modeal Examiner must be notified at 1 ☐ Yes 2 XNo Director Worcester Bishopville Maryland the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 23a or 72 hours after death with 21813 USA 11002 Piney Island Dr. 12. Was Decedent Ever in U.S. Armed Forces?
1★]Yes 2 □ No
If Yes, Give
Year or Dates.Navy or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc 1 □ Never Married 2 □ Married HABBART , Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white ≥ 3 Widowed 4 X Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry nd 2 should be filed within Ith and Mental Hygiene. 7 is marked and Elementary/Secondary (0-12) College (1-4or 5+) 12 assistant superintendent health care 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Virgil Gavin Dean Gladys Jones ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health and Important; If item 27 is n any injury or other traum 11002 Piney Island Dr., Bishopville, MD 21813 Rodney Dean/son 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition Dorchester Memorial 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4/14/09 Cambridge, MD 4 ☐ Donation 5 ☐ Other (Specify) Park 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 6 disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending a support of the contract of th burial-tran Due to (or as a consequence of): attending physician for use as the burial Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) signed by the a d be detached for P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably cate has been signated by page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a, Was an autopsy 212 No 1 Tyes director, 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 Accident completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature And title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month Day Vear **Physician** \mathbf{A}^{M} JEFFERY COLE FRAZIER 5:00 APRIL 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 306 BAY CITY ROAD STEVENSVILLE QUEEN ANNE'S 8. Date of Birth
(Month, Day, Year)
JUNE 11,1947 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** Days Months Hours 61 **MICHIGAN** 214-48-0713 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State show event, the Medical Examiner must be notified at 1 □Yes 2X No Director MARYLAND QUEEN ANNE'S STEVENSVILLE 28a-f 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number with 23a or 306 BAY CITY ROAD 21666 UNITED STATES death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Dayes 2 No If Yes, Given 69–1972 Year or Dates 69–1972 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2 X No Specify: WHITE <u>Ş</u> 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) FEDERAL COMMUNICATIONS and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) ELECTRICAL ENGINEER COMMISSION 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be WILLIAM RAY FRAZIER HAZEL PECK ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other training. ANN MARIE FRAZIER/WIFE 306 BAY CITY ROAD, STEVENSVILLE, MD 21666 Baltimore, 20b. Place of Disposition (Name of CROWNSVILLE) VETERANS 20a. Method of Disposition
1 PBurial 2 □ Cremation 3 □ Removal from State 20c. Location - City or Town, State Date Pages 1 APRIL 2009 14 4 ☐ Donation 5 ☐ Other (Specify) CEMETERY CROWNSVILLE, MD 21. Signature of Fun Service Licens FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** METASTATIC PANCREATIC CANCER 3 MONTHS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner Due to (or as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last death certificate be executed and burial-tran Due to (or as a consequence of): Box 68760 attending physician Physician/Medical the esn If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Month in the past 12 months? Day Year 5 Other (specify) signed by the a d be detached f ☐Yes 2☐No P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No 1 ☐Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Yes 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated, 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0067691 APRIL 9, 2009

State Registrar 31. Date filed (Month, Day, Year)

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MARK G. GOLDSTEIN, M.D., 2003 MEDICAL PARKWAY, SUITE G60, ANNAPOLIS, MD 21401

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** CHARLES H. FEVERYEAR April 20 2009 12:09 PM /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Upper Chesapeake Medical Center Bel Air Harford 8. Date of Birth (Month, Day, Year) 6/17/1924 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Days 117-14-4265 84 Pennsylvania Director Usual Besidence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 1 No Bel Air Director MD Harford 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21015 USA 1512 Hillside Drive Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ∏Yes 2 ☐ No if Yes, Give Year or Dates: WWII 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Experimental Equip. Tester Civil Service 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Stella Shearer Charles Feveryear ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1512 Hillside Drive, Bel Air, MD Lorna F. Feveryear/Wife permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Evans Eagle Crematory 4/22/2009

22. Name and Address of Facility 21. Signature of Juneral Service License Harkins Funeral Home, Inc., Delta, PA 17314 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) myseugh **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Lause (Lisease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably ↓ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an page 2 s has autopsy performed? Yes 20 No certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient ဠ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 ☐ Pending investigation the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0032299 | April 20, 2009 Name and address of person who completed cause of death (Item 23a) (Type, Print) 615 W. MacPhail Rd. Suite 106 Beldir, mod1014 avid 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar Cenous

DHMH 17 Rev 1/2001

			FOR	partment of Health and Menta <i>ertificate of Death</i>	Reg. No. 13336							
			Hegistrar 1. Decedent's Name (First, Middle, Last)	2. Dat	e of Death 3. Time of Death							
	Physicia /Medic		Helen N. Hoffman		4 8 09 22.53 M							
	Examin	er	4a. Facility Name (If not institution, give street and number) Carroll Hospital	4b. City, Town, or Location of Death Westminster	4c. County of Death Carroll							
1,007	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthd)	ay) If Under 1 Year If Under 24 Hrs. 8. Dat	te of Birth 9. Birthplace (State or Foreign							
	Director		214–38–2690 1□ M 2√ F 93 Yrs	Months Days Hours Min. (Mo. 7/2	onth, Day, Year) Couintry) 29/1915 MD							
	w w		Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or	Location	10d. Inside City Limits							
	Maryk f sho	to	MD Carroll Hampste	ad	1 □ Yes 2 ☑No							
	n the	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?							
	23a c		4123 Hillcrest Ave.	21074	USA							
	er dea	Funeral		Was Decedent of Hispanic Origin? (Specify Ye If Yes, specify Cuban, Mexican, Puerto Rican,	14. Race - American Indian, etc.) Black, White, etc.							
336	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ant, the Medical Evaning must be notified at	by F	1 □ Never Married 2 □ Married 1 □ Yes 2 [X]No If Yes, Give 3 □ Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2 ☐ No Specify:	Specify: white							
21215-0036	72 hou	Completed by	15 Decedent's Education 16a De	ecedent's Usual Occupation live kind of work done during most of working e. DO NOT use retired)	16b. Kind of Business/Industry							
121	within iene.	mple	Elementary/Secondary (0-12) College (1-4or 5+)	idance counselor	education							
	filed v Hygid other		5+ Gu		Middle, Maiden Surname)							
<u>lan</u>	should be f and Mental s marked o' umatic eve	To Be	Vernon A. Stump, Sr.	Daisy Mart	in							
Maryland				ailing Address (Street and Number or Rural Route								
	1 and 2 Health Iem 27 i	1 8		5 Hillcrest Ave., Hamps sposition (Name of crematory or other place) Date	stead, Md. 21074 20c. Location - City or Town, State							
ρ	ages ent of nt: If it		1KTBurial 2 ICremation 3 IBemoval from State	orematory or other place) ount UMC Cem. 4/16/200	19 Hampstead Md							
Baltimore,	permit. Pages 1 and Department of Heal Important: If item 2 any injury or other once.	1	21. Signature of Funeral Service Licensee M00741	22. Name and Address of Facility Eline								
<u> </u>	9 9 E # 8	5 5	Saula, L Lemmer	934 S. Main St., Hampst								
			23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.		Onset and Death							
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of)	difficile coliti	5							
7	Examiner											
	p ti	iner	Sequentially list conditions, if any, leading to the conditions of the cause. Enter Underlying Cause (Disease or Injury that initiated events c.									
	xecute and Il-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of)									
68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	edical E	d									
99	rtifical ng phy as th	Medi	IF FEMALE:									
Box	eath certifications attending points as	ian/l	23b. Was decedent pregnant 1 Live birth 2 Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of delivery Month Day Year							
0	the de y the a	Physician/M	1 ☐ Yes 2 12 No 9 ☐ Unknown	5 Uotner (specify)								
о, С	requires that the de been signed by the should be detached	by Pr	Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I.	3e. Did tobacco use contribute to the cause of death?							
ord	w require been sign should b	ted k	Timary dementia		1 Yes 2 No 3 Probably 4 Unknown							
Records,	e law r has be le 2 sh	Completed	Diabetes mellitus		4a. Was an autopsy findings available prior to completion of cause of death?							
al F	n: The ficate r, pag				□Yes 2 No 1 Yes 2 No							
Vital	Physician: r this certifica ral director, p	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Impatient 2 ER/Outp	26. Place of Death (Che attent 3 DOA Other: 4 Nursing Home 5	ck only one) ☐ Residence 6 ☐ Other (Specify)							
υot	ng Phy ter thi	on: To	27. Manner of Death 1 Matural 5 Pending 28a. Date of Injury (Month, Day, Year) Inju	ne of 28c. Injury at 28d. D	escribe how injury occurred							
SiOI	tendir eath. tor: Ai	catic	2 Accident investigation	M 1 □Yes 2 □No	Control Control Control Control Control							
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_	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page.	a C	29a. Certifier 1 Certifying Physician: To the best of my knowledge,	death occurred at the time, date and place, and di	ue to the cause(s) and manner as stated.							
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	10		30. Name and address of person who completed cause of death (Item 23a) (The PATRICK TURNES MD SCL	TE 102 1000 Liber	ty Rd Eldersburg, mo							
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	1								
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 04/07/2009 **Physician** Francis Joseph Hoff 6:00 A^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Brinton Woods Health Care Center Sykesville Carrol1 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 01/27/1920 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 XM 2 ☐ F Months Hours Min. 218-94-1855 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinating the notified at Director 1 ☐Yes 2XINo MD Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1206 Frizzell Rd. Funeral 21157 USA 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2至 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo þ Specify. Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, Item. College (1-4or 5+) Unknown Farmer Se1f 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Charles E. Hoff, Sr. Hilda M. Niner ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Buckingham/Sister 1206 Frizzell Rd., Westminster, MD 21157 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Providence Cemetery 4/10/2009 4 ☐ Donation 5 ☐ Other (Specify) Gamber, MD 21. Signature of Funeral Service Deensee 22. Name and Address of Facility Burrier-Queen Funeral Home & Crematory, P.A. 1212 W. Old Liberty Rd., Winfield, MD 21784 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, show, o heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Sal se (Final disease or condition resulting in death) **Physician** Sa sto eujo /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading I. cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) law requires that the death certificate be executed burial-tra Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.0. 1 Tyes 2 No. 9 Unknown been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à jelvelius 1 ☐ Yes 2 🔯 No 3 ☐ Probably 4 ☐ Unknown Completed alace 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No cate has by page 2 s 24a. Was an autopsy performed? certificate 1 □ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) dire 1 Tes 2 No this Medical Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After th funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation To the Hospital or AttendIng within 24 hours after death.

To the Funeral Director: Aftr completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

WJL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

84170 102

32. Registrar's Signature

2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year An 0 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Burtonsull MB MI 8. Date of Birth (Month, Day, Year) 04-30-1925 Birthplace (State or Foreign Country)
 MD 5. Social Security Number Age (In yrs. last birthday 1 1 M 2 F 83 220-12-9664 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 □ No Maryland | Prince George's Adelphi 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20783 USA 8402 Rambler Drive 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: Black 1 ☐ Yes 2 🗓 No 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation. 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) +02 Elementary/Secondary (0-12) Photographer Federal Government 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Regina Forrest John T. Holliday 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4940 East End, Unit 15C Chicago, IL 60615 Mary R. Mohammed/sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State Fort Lincoln Cemetery 04-20-2009 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 20746 Cedar Hill FH 4111 Pennsylvania Ave.Suitland,MD Mary M0137 gman 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death NEUMONIA Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Inknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performe 1□ Yes 2□No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ №6 Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA A ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Man r of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Natural 1 Tyes 2 Accident 6 ☐ Could not be 3 ☐ Suicide

Physician /Medical Examiner

Examine

Physician/Medical

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Completed

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Certification:

Medical

4 ☐ Homicide

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

29a, Certifier

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show dical Examiner must be notified at

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permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once.

Director

Funeral

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Completed

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72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

certificate be executed sician and burial-tran attending physician for use as the buria this certificate

After this To the Hospital or Attending Puthin 24 hours after death.

To the Funeral Director: After the completely filled in by the funera

Division or Vital Records, P.O. Box 68760,

2 BV

State Registrar Allelu

determined

29c. License number 285

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Sm1774

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

SUITE 203

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ASNEEM

32. Registrar's Signature

and manner stated.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

		_ For	State of Maryl	and / Dep	artment of H	lealth and N	Mental Hyg	iene o	00	1000
		State Registrar		Ce	rtificate of	Death	R	eg. No. 4	UY	1333
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and the second second second		1502 JERSEY	Rond		SALIS	DURY	La Data dell'alla		mice	
Funeral		5. Social Security Number 6. S	ex 7. Age (In	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 2/4 Hrs. Hours Min.	8. Date of Birth (Month, Day	, Year)_	Coun	ace (State or Foreign
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artme	-	21. Signature of Funeral Service Licer		OREEW 2	2. Name and Addre	ess of Facility	- 2009	24119	> , (0)[9
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affer Dire	Certification:	4 ☐ Homicide determined	28e. Place of injury - building, etc. (S _i	pecify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Tow			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
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To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Z	29b. Signature and title of certifier	1		29c. Licens	se number	2	29d. Date signe	d (Month,	Day, Year)
1		1 / illen	all life	ne m	0000	04500	1-	4-8	- 0	3
KW	-	30. Name and address of person who	completed cause of death	(Item 23a) (Type	Print)					
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Stat	е	31. Date filed (Month, Day, Year)	32. Rejistrar's S	Signature 🙎	1 31					

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 943M Harvey /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 54/156414 VICOMICO TENINSULD MEDICAL If Under 1 Year | If Under 24 Mrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Social Security Number **Funeral** Days Min 1 □ M 2 86274 -1963 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, I'm Madical Evandmar must be muithed at 1 ☐ Yes 2 ☐ No Worcester Director tocomoke 10e. Street and Number 10g. Citizen of What Country? LIS: A 2185 6002 treet Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □Yes 2 ▼No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 □Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify. by Blace 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "na any injury or other traumatic event, I'm Medie once. kind of work done during most of working PO NOT use refired) Elementary/Secondary (0-12) College (1-4or 5+) 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1es 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) ic host lisbury Nice lerone 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State 20a. Method of Disposition Date Burial 2 Cremation 3 Removal from State Pocomoke 111/2009 4 Donation 5 Other (Specify) gnature f Funeral Service License Selisbury NID 21801 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician 1 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Irijury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician ar s the burial-tr Due to (or as a consequence of): P.O. Box 68760 Physician/Medical attending p IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) the a 1 ☐Yes 2 ☐ No. 9 Unknown signed by to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy perform this certificate Division of Vital 1 □Yes 2 No 2 🗆 No Hospital or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) 1**⊠**Yes 2 □ No 1 ☐ Inpatient 2 K ER/Outpatient 3 ☐ DOA မ After the 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Naccident To the Funeral Director: completely filled in by the 6 ☐Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature 29d. Date signed (Month, Day, Year) 109

Registrar
DHMH 17 Rev 1/2001

State

30. Name and address

31. Date filed (Month

who completed cause of death (Item 23a) (Type, Print

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Day **Physician** Month Melanie Anne Harms ,2009 9.35 /Medical ton 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicom 100 Salisbur Rehabilitation + Nursing Ct lisbury If Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country)
 England 5. Social Security Number Date of Birth **Funeral** Days 1 □ M 2 🕶 F 10703/1961 217-15-1903 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f show nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla artment of Health and Mental Hygiene.
ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Exam in a transit by mellified at 1 X Yes 2 □ No Director Wicomico Salisbury Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21804 AptC by Funeral 405 Moss Hill Lane, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🏔 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🛣 No Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Domestic Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked c any Injury or other traumation. (unknown) Mae Anthony Bloxham 9 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 116 Glen Ave. Salisbury, Maryland 21804 Stephen Harms/husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State salisbury, Maryland 04/09/2009 Salisbury Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Live 22. Name and Address of Facility Home P.A. 501 Snow Hill Rd. Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Stagn end Ivh disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury requires that the death certificate be executed Exami burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician the burial P.O. Box 68760, Physician/Medical ed by the attending detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) ☐Yes 2☐No 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 Probably peen; 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No cate has t page 2 s 24a. Was an this certificate 1 □Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 1 Inpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 2 ER/Outpatient 3 DOA After thi funeral of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural neral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital e Funeral I 29a. Certifier certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the Hosp within 24 hor To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifia 29c. License number 29d. Date signed (Month, Day, Year)

30h

State

DHMH 17 Rev 1/2001

Registrar

6104

Year)

31. Date filed (Month, Day,

2001

Avenue, Salishar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ILWP

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2009 April 6, **Physician** Clifford Herman Insley Jr. 11:45 a^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 20572 Nanticoke Road Nanticoke Wicomico 8. Date of Birth (Month, Day, Year) 06/24/1935 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Months Days Hours 1**⊠**M 2□ F 73 Maryland **Director** 214-34-7270 Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantment must be notified at 1 ☐ Yes 2 ☑ No Director Wicomico Maryland Nanticoke 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 21840 20572 Nanticoke Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Tyes 2 No
If Yes, Give National
Year or Dates: Guard 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ∐Yes 2 No Specify. Specify: white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) waterman/farmer seafood/agriculture 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hilda Blanch Horseman Herman Clifford Insley, Sr. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20572 Nanticoke Rd., Nanticoke, MD 21840 19a. Informant's Name/Relationship (Type. Print Marquerite Insley/wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Tyaskin U.M. Church
Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Buria! 2 ☐ Cremation 3 ☐ Removal from State 4/11/09 Tyaskin, MD 4 ☐ Donation 5 ☐ Other (Specify) Sign and of Funeral Service Licensee Thorioway Fufferal Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Carcinoma Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed burial-trar Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) P.0. 9 Unknown ģ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s autopsy performed? 1 Yes 2 No certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ို this After this funeral c 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 4.0 030690 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 145 E Caroll St. 501:55000 MD 21801 MARTIN Jomes 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

			1- State of Maryland State of Maryland	d / Depa <i>Cei</i>	artment of <i>rtificate c</i>	f Health and of Death		giene∪ ↓ Reg. No.	JJ	13343
			Decedent's Name (First, Middle, Last)				2. Date of Dea	ıth		3. Time of Death
	Physic /Medi		Mary Grace Isennock				April	19, 2	0 0 9	1:30 P
	Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town	n, or Location of Dea		4c. Coun	ty of Death	
			15605 Home Road		Spar	ks			alti	more
	Funeral		5. Social Security Number 6. Sex 7. Age (<i>In yrs. li</i> 21.6 - 2.4 - 5.4.75 1□ M 2점F 8.3	•	If Under 1 Ye Months Dar			Yeer)	Cou	place (State or Foreig
	Director		210 24 3473	Yrs.		,0	Oct. 26	, 1925	Mar	y1and
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City	Town or Lo	ocation					10d. Inside City Limits
	sho	ŏ	MD Baltimore	Spar						1 □ Yes 2X No
	the N	ect	10e. Street and Number	DPur.	10f. Zip Cod	•	1	10g. Citizen of	What Cou	ntn/2
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	eath	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S.	3. 13.		of Hispanic Origin? (Specify Yes or No-	U • S	• A •	can Indian.
	iner d	Fun	Armed Forces?		If Yes, specify C	uban, Mexican, Puè	rto Rican, etc.)		ack, White,	etc.
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21215-0036	within 72 hours after death with the Maryland ane. Then "natural", or Items 23a or 28e-f show is Mudical Examiner must be notified at	Completed by	15. Decedent's Education	16a. Dece	dent's Usual Oc	cupation	-dia-	16b. Kind of I	Business/In	dustry
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Maryland 21	filed with Hygiene. other ther	ő	11	Pos	tmistr	ess		U.S.	Post	Office
	be filed tal Hygi d other	Be	17. Father's Name (First, Middle, Last)			18. Mother's Na	me (First, Middle,	Maiden Suma	me)	
	should be nd Mental marked o	ပု	John Henry Hoover			Ada M	lae Down	.S		
la l	2 sho and is mu	8	19a. Informant's Name/Relationship (Type, Print)			eet and Number or F				Code)
Baltimore, N	of Health of Health If item 27 or other tr	1 3	Mona Jean Isennock, Daughter			Road, S		MD 21		
			20a. Method of Disposition 1	metery crer	sition (Name of matory or other p DELST CEI EFORD	nefery Apr	11 24 .	20c. Location		
	tmen tant: jury							Parkto		
Bal	permit. Pag Department Important: any injury c		21. Signature of Funeral Strvice Licensee			dress of Facility J				
	402 % Q		23a. Part1. Enter the disease, or complications that caused the death.			nd St.,			PA	Approximate
	Physician and bulkaring street be executed by sician and street s	Examiner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or consequen	ence of):	Gn	w pulm Colim	un de	reage	2	Interval Between Onset and Death 20 403
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.O. Box	The law requires that the death certific ate has been signed by the attending r age 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 montbs? 1 ☐ Yes 2 ☐ HO 9 ☐ Unknown 23c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3	Ectopic pregna Other (s <i>pecify)</i>				ate of delivi	ary Day Year
Ω.	that ned b		Part II. Other significant conditions contributing to death but not resul	ting in the ur	nderlying cause	given in Part I.	23e. Did tol	bacco use cor	ntribute to t	he cause of death?
g	quires n sign ld be	d b	Coroner aftern dise	22	3/05	leit.	1 □ Ye	es 2 No	3 ☐ Prol	oably 4 Unknown
S	w require been signatured should b	Completed by			10		24a. Was a	n 24b.	Were auto	posy findings available
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of Vital Records,	Physician: this certific ral director,	0 0	examiner?	R/Outnation	t 3 DOA	Othor	ath (Check only on Home 5 Heside		her /Specii	(v)
o		 	27. Mann Death 28a. Date of Injury	28b. Time of	28c. In	jury at	28d. Describe ho			y)
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	To the Hospital or At within 24 hours after of To the Funerel Directompletely filled in by	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my know and manner stated.	ledge, death on and/or inv	n occurred at the restigation, in m	time, date and plac y opinion, death occ	e, and due to the ca urred at the time, da	ause(s) and mate and place	nanner as s , and due to	tated. the cause(s)
	To the within 2 To the Complet	ž	29b. Signature and sittle of certifier	1	29c. Lice	ense number		9d. Date sign	ed (Month)	Day, Year)
	-		> MANGODOLOWN	P		019153	5	4/-	20/0	9
			30. Name and address of person who completed cause of death (Item	23a) Type,	Print)		1692	1 Yor	k Ro	ad d
_		50	MARKE S. KAFLAN	MI	0		Monkt	on, M	D 21	111
4	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signatu	ire	1					

DHMH 17 Rev 1/2001

State Registrar

Physician /Medical Examiner The law requires that the death certificate be executed burial-tran Division or Vital Records, P.O. Box 68760, attending physician for use as the buria

Physician

/Medical

Examiner

MD

Director

Funeral

þ

Completed

Be

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notifiled at once.

by Physician/Medical detached Be Completed page 2 s To the Hospital or Attending Phywithin 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral or

Examiner

1 □ Yes 2 □No 9 □ Unknown	4⊔Pregnant at time of deat	th 5∐Other (s	specity)	
	ns contributing to death but not resulting	ng in the underlying		
MRSA	CEULLITIS	K16A1	100	/ "

(Month, Day

28e. Place of injur-building, etc.

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				26.	Place of Dea	th (C	heck only	one)			
2	ER/Outpatient	3 🗆 [DOA O	ther: 4	Nursing H	lome	5 □ Res	idence 6	□Other (Spe	ecify)	
Year)	2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of Injury M Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 Yes 2 No										
/ - At h (Specii	ome, farm, stree	et, facto	ory, office	е		28f.		(Street and wn, State)		ural Route Number,	
	owledge, death o									s stated. e to the cause(s)	

0	1 ☐ Yes 2 ☐	No
Medical Certification: To	27. Manner of Deat 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	h 5 ☐ Pending investigation 6 ☐ Could not be determined
edical (29a. Certifier (Check only one)	1 Certifying Phy 2 Medical Exam
ž	29b. Signature and	title of certifie

a Physician: To the best of Examiner: On the basis of examiner stated 29d. Date signed (Month, Day, Year)

29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ronald Miller , MD 4 Culdwell Dr. Mt. Airy, MD 21771

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature

51 3

Hospital or Attending Physician:

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Harriett Anne Glynn James РМ April 9 2009 8:30 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Wilson Health Care Center Gaithersburg Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday 6. Sex Funeral Months Days Hours 1 □ M 2 🗷 F 87 227-12-1420 Virginia Director Sept. 19 1921 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at Gaithersburg 1XYes 2 No Director Md. Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natura" any injury or other traumatic auce. United States 20879 301 Russell Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 Mano If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 M Married 1 ☐Yes 2 No White Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harriett W. Brennerman Joseph Glynn, Jr. John ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7 Puritan Court, Damascus, Maryland 20872 Daniel R. James / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗷 Burial 2 □ Cremation 3 □ Removal from State 6/8/09 Arlington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Arlington National 22. Name and Address of Facility 21. Signature of Fune/al Service Licensee, Muriel H. Barber Funeral Home m-00970 P. O. Box 5038, Laytonsville, Md. Approximate Interval Between Onset and Death 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shork, or heart failure. List only one cause on each line. immediate Cause (Final Physician Tens disease or condition resulting in death) /Medical Due to (or pa consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner cate has been signed by the attending physician and page 2 should be detached for use as the burial-transi resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 mor Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part I. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 1 🗆 Yes 2 🗹 No 3 ☐ Probably 4 ☐ Unknown Completed Was autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 🗀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Mann of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 PNatural 5 Pending 1 ☐ Yes To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu death. investigation 2 🗆 No 2 Accident Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 29a. Certifier l 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 04165 30. Name and address of person who completed cause of death (Item 23a) (Type, Print 4 Policy Charles of the Complete Cause of death (Item 23a) (Type, Print Charles of the Complete Cause of death (Item 23a) (Type, Print Charles of the Complete Cause of death (Item 23a) (Type, Print Charles of the Complete Cause of death (Item 23a) (Type, Print Charles of the Complete Cause of death (Item 23a) (Type, Print Charles of the Complete Cause of death (Item 23a) (Type, Print Charles of the Complete Cause of death (Item 23a) (Type, Print Charles of the Complete Cause of the Cause of the Complete Cause of the Complete Cause of the 1. Date filed (Month, Day, 32. Registrar's Signature Year) Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 3346 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 9, 2009 Year Gloria Elaine Johnson 5:07 A M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 7900 Ashdale Road Capitol Heights, MD Prince Georges 8. Date of Birth (Month, Day, July 8, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1941 Days Hours 1 □ M 2√□ F Washington, DC 577-58-5773 67 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1√2Yes 2□No Maryland Prince Georges Capitol Heights, 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20743 7900 Ashdale Road United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes Ž☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Never Married 2 ☐ Married Specify Black 1 □Yes 2 No Specify.

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Data Entry Clerk

16b. Kind of Business/Industry

Healthcare

18. Mother's Name (First, Middle, Maiden Surname)

Kathlyn Bush Clark

death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examinar Instal by notified at once. Baltimore, Maryland 21215-0036

1 - For State Registrar

10a. State

3 X Widowed 4 □ Divorced

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

Earl Thomas Clark

15. Decedent's Education (Specify only highest grade completed)

College (1-4or 5+)

Director

Funeral

ğ

Completed

Be

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Physician

/Medical

Examiner

Funeral

Director

Physician /Medical **Examiner**

ertificate be executed burial-transi and the attending the signed by t d be detach page 2 should To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate h completely filled in by the funeral director, page

Division of Vital Records, P.O. Box 68760.

19a. Informant's Name/Relationship (Terrence Johnson		19b. Mailing Addre	ss <i>(Street and Number or I</i> gh t Court, U I	Rural Route Number, City oper Marlbor	or Town, State, .	Zip Code) 077 2
20a. Method of Disposition	ľ		ame of	Date 20c.	Location - City or	Town, State
1 Burial 2 Cremation 3 4 Donation 5 Other (Specif	Hemoval from State		erans Cem. 4,	/16/2009 Che	ltenham,	, MD
21. Signature of Funeral Service Light			and Address of Facility		estville	
Lange d.	Jemmon	Pope 1	Funeral Homes	s, P.A. 5538	Marlbon	co Pike
23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Fir al disease or condition	plications that caused the dea one cause on each line. Dementia	th. Do not enter the me	ode of dying, such as cardi	ac or respiratory arrest,		Approximate Interval Between Onset and Death
resulting in death)	Due to (or as a consec	quence of):				
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consec	quence of):				
Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a consec	quence of):				
	d					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of pregn 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3 🗆 Ectopic			23d. Date of de Month	elivery Day Year
Part II. Other significant conditions of	contributing to death but not res	sulting in the underlying	cause given in Part I.			o the cause of death?
				24a. Was an autopsy performed?	prior to	utopsy findings availab completion of cause of
25. Was case referred to medical examiner?				eath (Check only one)		
1 ☐ Yes 2 💢 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 ☐ I	DOA Other: 4 Nursing	Home 5X Residence	6 ☐ Other (Spe	ecify)
27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how inj		
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	e 28e. Place of Injury - At h building, etc. (Spec	ome, farm, street, factorify)	ory, office	28f. Location (Street a City or Town, Sta	and Number or R ite)	ural Route Number,
29a. Certifier (Check only cne) 1 Certifying Pr 2 Medical Exam	nysician: To the best of my kn miner: On the basis of examin and manner stated.	owledge, death occurre ation and/or investigati	ed at the time, date and pla on, in my opinion, death oc	ace, and due to the cause courred at the time, date a	(s) and manner a nd place, and due	e to the cause(s)
29b. Signature and title of certifier	2-00	2	9c. License number	29d. E	ate signed (Mont	th, Day, Year) 2009
30. Name and a ss of person who	completed cause of death (Ite	m 23a) (Type, Print)	Ste 700 L	ARESO, MD	20974	1

State Registrar

BI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- State Amended item#8,3.9.09, WCHD, SLU Certificate of Death

Registrar

Registrar

Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year 55 PM acobs ary izabeti 04 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Hospic at Comic If Under If Under 24 Hrs 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Date of Birth (Month, Day, Months Days Hours Min 1 □ M 2 K F 215-26-2696 Director 1/4/1928 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Mydical Examiner must be notified at MD Director 1 ☐ Yes 2.☐ No Wicomic Mardela Springs 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or School 2183 Funeral 1564 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No items. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☑
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 than "natural", or 1 ☐Yes 2 ☐No Specify: \$ Blac 3 ₩idowed 4 ☐ Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien. Important: If them 27 is marked other the any Injury or other traumatic. Wrsing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be Martha Watts tani ပ James 19a. Informant's Name/Relationship (Type. Print) Dunghter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hardela Springs No 21837 Domic)an Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State Sharpton MD 4 ☐ Donation 5 ☐ Other (Specify) inetu 21. Signiture of Juneral Service Lice 22. Name and Address Isabsalla Streat in Sedistry Nie 21501 trunered Home Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner OFONAL Equantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed Due to (or as a consequence of) burial-Box 68760 physician Physician/Medical the attending pl IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) signed by the a P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ icate has been significate has been significated by page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Physician: The certificate performe Division of Vital 2 □ No 1 ☐Yes 2 No 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day, Year) Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No 24 hours after deatl filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 2 the 29b Signature and little of certifier 0 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

31. Date filed (Month

arke

0. Name of daddress of person who completed cause of death (Item 23a) (Type, Print)

egistrar's Signatur

09

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death APRIL 19, **Physician** RUSSYL L. JEPPESEN 20009 7:10 A /Medical 4a. Facility Name (If not institution, give street and number)
HOMEWOOD AT WILLIAMSPORT 4b. City, Town, or Location of Death 4c. County of Death Examiner WILLIAMSPORT WASHINGTON If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 1 1 M 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 3/8/1918 9. Birthplace (State or Foreign Funeral Months Days Hours Min. I DAHO 517-07-6474 91 Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10h County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Wedical Examiner must be notified at W۷ Director BERKELEY MARTINSBURG 1 ☐ Yes 2 X No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 287 WHITE OAKS DRIVE 25404 USA Funeral death v 12. Was Decedent Ever in U.S. Armed Forces? 1) Wes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 2 should be filed within 72 hours after on and Mental Hygiene.

is marked other than "natural", or itel 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 □ Yes 2X No Specify: WHITE Specify: þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) TRACTOR MANUFACTURER Elementary/Secondary (0-12) College (1-4or 5+) COMPUTER PROGRAMMER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LORENZO R. JEPPESEN ETHELYN JOY SECRIST 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health an
Important: If item 27 is 1
any Injury or other traus GEORGIA JEPPESEN/DAUGHTER 287 WHITE OAKS DRIVE, MARTINSBURG, WV 25404 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition APRIL Date 1 ☐ Burial 2XXCremation 3 ☐ Removal from State SMITHSBURG CREMATORY 23, 2009 SMITHSBURG, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BROWN FUNERAL HOME, PO BOX 821, Charles M. 327 W. KING ST., MARTINSBURG, WV 25402 ian 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Preumonia Idau disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician ar s the burial-ti Due to (or as a consequence of): P.O. Box 68760, Physician/Medical attending p use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 5 Other (specify) 1 □ Yes 2 □ No. the 9 Unknown 9 Unknown ģ signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ⋧ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an cate has t autopsy certificate 1 ☐Yes 2 ☑No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To After thi funeral of 28a. Date of Injury (Month, Day, Year) 27. Manuar of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Natural 5 Pending within 24 hours after used...

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Kuther-Sand, ~ April 20,2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Church Road, Hagerstown, Maryland Cynthia Kuttner-Sands up 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician ^{Day} 2009 Edvthe Kley 11:49 AM April 8, /Medical 4a. Facility Name (If not institution, give street and number)
Carroll Hospital Center 4b. City, Town, or Location of Death Westminster 4c County of Death Examiner 8. Date of Birth (Month, Day, Year) If Under 24 Hrs. Hours Min. 5. Social Security Number If Under 1 Year NY Country 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 1 F Months Days 1915 **Director** 068-01-0435 Usual Residence of Decedent 10b. County Carroll 10a. State MD 10d. Inside City Limits show 10c City, Town or Location Westminster permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any Injury or other traumatic event, the Medical Examination must be motified at Director 1 ☐ Yes 2 No 10f. Zip Code 21158 10g. Citizen of What Country? 10e. Street and Number 819 Hughes Shop Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status 1 Yes 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2€ No Specify: <u>ک</u> Specify: 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) TRM Executive Secretary 18. Mother's Name (First, Middle, Maiden Surname)
Isabelle Brandt 17. Father's Name (First, Middle, Last) Be Joseph Weinrod 2 ^{19a.} Informant's Name/Belationship (*Type. Print*) Lynne Dalrympie – Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 819 Hughes Shop Rd., Westminster, MD 21158 20b. Place of Disposition (Name of cemeters, crematory or other place)
Carrol Cremations Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/9/2009 Hampstead, MD 21. Signature Funeral Service Licensee 22. Name and Address of Facility Pritts Funeral Home & Chapel, P.A. 412 Washington Rd., Westminster, MD 21157 de 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ටිල් meunin /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, acting to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed Musel and Due to (or as a consequence of) attending physician a for use as the burial-Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Vear Day Pregnant at time of death 5 ☐ Other (specify) o signed by the a 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown should I Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy certificate 1 □Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dii Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 142 Certifying Physician: To the best of my knowledge peath occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 1)37aua

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DHMH 17 Rev 1/2001

Registrar

30. Name and address of person who compl

31. Date filed (Month, Day,

ed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatur

22

State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Kuano 2009 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltimore (OUNT 7. Age (In yrs. last birthday) If Under 1 Year Date of Birth (Month, Day, Year) 6. Sex **Funeral** Days 1**X** M 2□ F Yrs Director 11/18/1941 110-32-4658 67 NY Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show notified at 1X∏Yes 2 ☐ No Director OUEEN ANNE'S CRUMPTON MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with "natural", or items 23a or 211 4TH STREET 21628 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Xes 2 □ No 1959— If Yes, Give Year or Dates: 1962 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced WHITE Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natur any Injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PAINTER CONSTRUCTION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HOMER KNAPP ELIZABETH ERMAK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) ROBERT A. KNAPP, JR/SON 208 DUKE OF KENT ST. CHESTERTOWN, MD 21620 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 1 5 Other (Specify, CHESAPEAKE CREMATION 4/7/2009 STEVENSVILLE, MD Funeral Service 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 21. Signatu Mou 130 SPEER RD. CHESTERTOWN, MD 21620 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** omentia /Medical Due to (or as a consequence of) Examiner active fulmonary Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔲 lopatient 2 ER/Outpatient 3□ DQA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 ☑ Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 👱 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of Attifier 29c. License number 29d. Date signed (Month, Day, Year) ddress of person who completed cause of death (Item 23a) (Type, Print) Sayed, MD Levindale 2434 W. Belvedere Avenue, Baltimore 31. Date filed (Month Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month O Day Year 5:67 AM Mary F. Kirby 10 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death at Say nastal Hospice Q isbur wicomica If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign Hours Months 1 □ M 2 🖺 F Days Min. 212-60-9408 58 Dec. 19, 1950 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d Inside City Limits Wicomico Delmar 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12 W. Elizabeth Street 21875 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Race - American Indian 1 □ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No Specify. 3 Widowed 4 Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Delores Viola Truenberg J.C. Baker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12 W. Elizabeth St. Delmar, MD Jason Kirby (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematory of Delmarva 04-12-2009 Delmar, Delaware ature of Funeral Service Licensee 22. Name and Address of Facility
Short Funeral Home 13 E. Grove Street Delmar, DE Approximate Interval Between Onset and Death Due to (or as a consequence of): Due to (or as a consequence of): ren 100 Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Day Year 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy

Physician /Medical Examiner

permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygien Important: If Item 27 is marked other the any injury or other traumatic event, I agines.

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

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MD

If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Wide Levin incomest he notified at

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Baltimore, Maryland 21215-0036

sician and burial-trans attending p for use as t detached sign be page 2 should has director, this the funeral After

Hospital or Attending Physician: The law requires that the death certificate be executed

after death

thin 24 hours a

within To the

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filled in by

P.O. Box 68760,

Division of Vital Records,

Exan	t
Physician/Medical	1 2
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23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last iner FEMALE 3b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown art II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 24b. Were autopsy findings available prior to completion of cause of death? perforn 2 🗆 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) Residence (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 3 Suicide Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide cal 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Charles Kraft JR /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** RURITANRO CAROLINE ENTON 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day) (State or Foreign **Funeral** Months Days Hours Min 214-54-1156 Director Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 ▼No Director CAROLINE DENTON 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe ò 21629 23a DRITAN Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ö 1 ☐Yes 2 No If Yes, Give Year or Dates Specify ģ 3 Widowed 4 Divorced 'natural", Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) GENERAL CONTRACTOR HOME IMPROVEMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be William CharLES KRAFT SR. HARLOTTE F 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 I 3001 BERO RD. BALTIMORE KRISTOPHER W. KRAFT, SR., Pages 1 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages
Department of I
Important: If its
any Injury or o 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4-22-09 GENBURNIE MD. 4 ☐ Donation 5 ☐ Other (Specify) Facility DAUGHERTY FUNERAL HOME MOUNTAIN RD. PASADENA, MD. Z1122 23a. Part 1. Enter the disease Approximate Interval Between Onset and Death complications that Do not enter the mode of dving, such as cardiac of respiratory arrest. shock, or heart failure Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the burial-transi and ding physician certificate be Physician/Medical as nse 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery atten 3 🗆 Ectopic pregnancy for Month Day Year 5 ☐ Other (specify) signed by the a Ö 9 Unknown ď significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ Mellitus 1 Yes 2 No 3 Probably 4 Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has the lirector, page 2 standard autopsy performed? Yes 2 No of Vital 1 ☐ Yes سارت the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) After this . Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: Division or Attending 1 Natural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in within 24 hours a

To the Funeral D Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29b. Signature and atle of certifier 29c. License number 29d. Date signed (Month, Day, Year) 26656 20/09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4000 ANNISPOUS CALDERON JORGE

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

backs

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** APRIL Charles 8:45 AM 10 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1013 LONG POINT ROAD GRASONVILLE QUEEN ANNE'S Social Security Number If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year)

JANUARY 22, 1929 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 X M 2 □ F Director 80 **MARYLAND** 218-22-4813 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, the Medical Evanings must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2X No MARYLAND QUEEN ANNE'S **GRASONVILLE** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1013 LONG POINT ROAD 21638 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐Yes 2 X No Specify: þ If Yes. Give KOREAN Specify: WHITE 3 ₩ Widowed 4 Divorced Year or Dates: WAR Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) INDUSTRIAL ENGINEER 4 RETAIL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Department of Health and Mental Important: If item 27 is marked o any injury or other traumatic eve UNKNOWN CHARLOTTE SCHWAB ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOHN R. LITTLE/SON 1013 LONG POINT ROAD, GRASONVILLE, MARYLAND 21638 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) APRIL 14 20c. Location - City or Town, State 1 Ma Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) DRUID RIDGE CEMETERY 2009 BALTIMORE, MARYLAND 21. Signar re of uneral Service Licensee, 22. Name and Address of Facility
FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Metastatic adeno carcino ma disease or condition resulting in death) /Medical Due to (or as a consequence of): xaminer Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence of cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗌 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1 ☐ Yes 2 Mo Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Presidence 6 Other (Specify) Certification: To 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manne of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: A 2 Accident investigation 1 ☐ Yes 2 ☐ No filled in by the 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical npletely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of contifier 29c. License number 064374 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1830 E. Monument St, Baltimore, M.D 21287 31. Date filed (Month. gistrar's Signature Registrar

DHMH 17 Rev 1/2001

			1 - State Registrar			(Certificate of	Death		Reg. No.			
			1. Decedent's Nam	e (First, Middle, La	st)				2. Date of De		V	3. Time of Death	
	Physici /Medi		DANIE	EL LIGO	V.				Month APRIL	Day 9	2009	12:55 P	
	Examir		4a. Facility Name (If not institution, giv	e street and number	7)	4b. City, Town, o	or Location of Death		4c. Count	y of Death	1	
			316 Asht	on Road			Ashte	on		Mon	tgome	ery	
	Funeral		5. Social Security N			ge (In yrs. last birth	day) If Under 1 Year		8. Date of Birt (Month, Da	h v Vear)	9. Birth	place (State or Fore	
	Director		220-01-1533 88 Yrs. June 5										
	and *		Usual Residence o 10a. State	10b. County		10c. City, Town	or Location					10d. Inside City Limi	
	after death with the Manylan or Itame 23a or 28a-f show	ō	Md.									1 Tes 2 1	
	28a	ec	10e. Street and Nu	mber		_1	10f. Zip Code			10g. Citizen of	What Cou	intry?	
	with Ba or	Funeral Director	316 Asht	on Road				20861		-	United States		
	Jeath me 2:	era	11. Marital Status		12. Was Deceden	t Ever in U.S.	13. Was Decedent of I	Hispanic Origin? (Sp	ecify Yes or No	- 14. Ra		ican Indian,	
10	fter o	E		ied 2 Married	Armed Forces				Rican, etc.)	Bla	ack, White,	, etc.	
936	urs af	þ		3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: WWII 1 ☐ Yes 2 🗷 No Specify:						Specia	^{fy:} Wh	nite	
Maryland 21215-0036	72 hours after death with the Maryland natural; or Itame 23a or 28a-f show dient Exartiner meat be motified at	Completed	(Soe	15. Decedent's E	ducation	16a. [Decedent's Usual Occu	pation	ına	16b. Kind of E	3usiness/Ir	ndustry	
2	within 7 ene. than "r	du	Elementary/Seco		College (1-4or	5+)	Give kind of work done life. DO NOT use retire	ed)	9				
21	ygien rer th	ပ္ပ	12		4		Owner				Utility Company		
nd	gas 1 and 2 should be filed within to theath and Mental Hygiene. If item 27 le marked other than "or other traumatic event, in the Mental traumatic event, in the Mental traumatic event, in the Mental traumatic event, in the Mental traumatic event, in the Mental traumatic event, in the Mental traumatic event, in the Mental traumatic event, in the Mental traumatic event, in the Mental traumatic event, in the Mental traumatic event, in the Mental traumatic event.	Be	17. Father's Name	(First, Middle, Last,)			18. Mother's Name			,		
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≥ .			Anne Lig	gon Falls	/ Daughte	er 22	110 Goshen	School Ro	oad, Ga:	ithersb	urg,	Md. 20882	
Baltimore,			20a. Method of Dis		Removal from State	I comoton	Disposition (Name of , crematory or other pla	ace)	Date	20c. Location	- City or T	own, State	
	Page nent nnt: It		` 4 □ Donation	5 Other (Specil	y)		ide Cemete	ry 4/1	1/09	Brinkl	ow, N	Maryland	
	permit. Page Department of Important: If any injury or		21. Signatury of F	reral Service Liger			22. Name and Addre	ess of Facility H. Barber	r Funera	al Home			
	00240		YOU	Cente	m-006		P. O.	Box 5038,	Layto	nsville	, Md.		
			23a. Part1. Enter 1 shock, or hea	the disease, or com art failure. List only	plications that cause one cause on each	od the death. Do no line.	ot enter the mode of dyi	ing, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death	
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1	/Medical Examiner		resulting in death)		•	s a consequence of	•						
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	p #	Examiner	Sequentially list contains any, leading to a cause. Enter Under Cause (Disease or	erlying	Dua to (or a	e a consecuence of) -						
	be executed sicien and burial-transit	am	Cause (Disease or that initiated event resulting in death)	5	c								
0	e exe ien a urial-		resulting in death)	Last	Due to (or a	s a consequence of):						
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99	certificate be executed Iding physicien and Ise as the burial-transi	/Medical	IF FEMALE:	1.									
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ita	certifican: rector.	0	25. Was case refe	rred to medical				26. Place of Deat					
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0			27. Manner of Dear		28a. Date of Inj (Month, D	ury 28b. Ti	me of 28c. Inju	iry at	28d. Describe f	now injury occu	rred		
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Division	Attener deat	ific	3 Suicide 4 Homicide	6 Could not be determined	286. Place of Ir	njury - At home, fare	n, street, factory, office		28f. Location (5 City or Tox	Street and Num	ber or Rur	ral Route Number,	
Ō	spital or A ours after neral Directilled in by	Certification:		4	ballang, e	etc. (Specify)			July 31 10V	, 0.1410/			
	e Hospital 24 hours a Funeral etely filled	;al (29a. Certifier	1 Certifying Pl	ysician: To the bes	t of my knowledge,	death occurred at the ti	ime, date and place,	and due to the	cause(s) and m	anner as :	stated.	
	To the Hos within 24 ho To the Func completely i	edical	(Check only one)	∠∐ Medicei Exar	niner: On the basis and manner s	of examination and stated.	or investigation, in my	opinion, death occur	ed at the time,	date and place,	and due t	o the cause(s)	
	To the within To the Comp	Me	29b. Signature and	title of certifier	- 0			se number		29d. Date signe			
	_			obest for	10x MI		D	34740		Apri	1 10.	, 2009	

DHMH 17 Rev 1/2001

State Registrar

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ORIGINAL

32. Registrar's Signature

18109 Prince Philip Dr., #200, Olney, Md.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert Fields, M.D.

APR LO ZUUS

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 19 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2009 1952 P ^M APRIL 6, COLLINS LAMOTTE ELIZABETH 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) KENT CHESTERTOWN HERON POINT If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 5. Social Security Number Days Months 1 ☐ M 2 🛣 F MD 4/23/1930 78 547-48-5141 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 ☐ No CHESTERTOWN MARYLAND KENT 10g Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21620 318 HERON POINT Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married Specify: WHITE 1 ☐ Yes 2 🗓 No Specify 3 XWidowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) SARAH WOOFINGTON MORRIS JOHN HARDING COLLINS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5910 QUAKER NECK ROAD CHESTERTOWN, MD 21620 DAVID LAMOTTE 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) STEVENSVILLE, MD CHESAPEAKE CREMATION CNTR. 4/7 21. Signature of Funeral Service Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME Duck CHESTERTOWN, MD 21620 130 SPEÉR RD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death DYSPHAGIA Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): CENEBROVAS CILLAR ACCIDENT POSSIBLE sequentially flat conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence ot) Due to (or as a consequence of) IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 ☐ Yes OSTEUPORUSIS 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy performed Yes 21 1∏ Yes

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

Completed by

Be

Funeral

Director

should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

al Hygiene.

Mental

Pages 1 and 2 sl ment of Health an ant: If Item 27 is r lury or other traur

Department of Important: If any Injury or

Examiner Physician/Medical ò Completed

Be

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Certification:

Medical

1 Yes 2 No

27. Marther of Death

1 Natural

3 ☐ Suicide

29a. Certifier

2 Accident

4 Homicide

burialphysician the attending p for use as use as the signed by the page certificate After this

requires that the death certificate be executed

P.O. Box 68760,

Division or Vital Records,

al or Attendi s after death.

within 24 hours at To the Funeral D Hospital

the

filled in by

25. Was case referred to medical examiner?

26. Place of Death (Check only one Other: 4 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify)

28a. Date of Injury (Month, Day Year) 28b. Time of 5 Pending investigation 6 ☐ Could not be

28d. Describe how injury occurred 28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Secritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

(Check only one) and manner stated. 29b. Signature and title of certifier Vd

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 000 0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Helen Noble, M.D. 122 Speer Rd. Chestertown, MD

State Registrar

2

32. Registrar's Signature 31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Lokey George 100 A Tocil 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Solisbury Rehabilitation & Nursing Ctr If Under 24 Hrs Wicomico 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) 5. Social Security Number Date of Birth (Month, Day, Year) **Funeral** Hours Months Days 92 214-10-9798 Director 12/24/1916 Maryland Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State 28a-f show traumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No Director Maryland Wicomico Salisbury 10f Zin Code 10g. Citizen of What Country? 10e, Street and Number ō 21804 414 Truitt St. USA items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No Black, White, etc. 1 X Yes 2 No
If Yes, Give
Year or Dates: Army 72 hours after 1 ☐ Never Married 2 ☐ Married 21215-0036 ò 1 ☐ Yes 2 🕱 No Specify. Be Completed by Specify: white 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) clothing manufacturing Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: If item 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) plumbing 12 worker/plumber 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Wallace Lokey Minnie McAllister ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5834 Airport Rd., Salisbury, MD 21804 Bonnie Walston/daughter other more, Date 20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Department of Important: If it any injury or conce. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Parsons Cemetery 4/9/09 Salisbury, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 (bompoor 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Securified list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been sinned by the control of the Funeral Director. cate has been signed by the attending physician and page 2 should be detached for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 1 ☐ Live birth 2 ☐ Fetal death 3 🗆 Ectopic pregnancy Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 1 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 🗆 No 2 No To the Funeral Director: After this certific 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 LNO Certification: To 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 🖳 Natural 1 ☐Yes 2 No 2 Accident 3 🗌 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 11 4 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical

Registrar DHMH 17 Rev 1/2001

State

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29b. Signature and title of certifie

William

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29d. Date signed (Month, Day, Year)

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and manner stated.

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kobins

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** /Medical 4a. Facility Name (If not institution, give street and number Town, or Location of Death 4c. County of Death Examiner Year If Under 24 Hrs. 8. Date of Birth (Month, Day, June 20 9. Birthplace (State or Foreign s, last birthday **Funeral** 1 □ M 2 1 F Hours Min 74 Maryland Director 1934 20-30-4852 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Exar when yest be notified at Director 1 ☐ Yes 2 No MD Washington Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a or 13619 Grandview Dr. 21742 U.S.A. Funeral items ; 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married altimore, Maryland 21215-0036 ò 1 □Yes 2 X No If Yes, Give Year or Dates: Specify: 2 Specify: 3 ☑ Widowed 4 ☐ Divorced White "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 7 is marked other than traumatic event, I'm W College (1-4or 5+) Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Norman Greenwell Anna Muriel Kennedy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a Sharon D. Goodwyn/Daughter 13619 Grandview Dr., Hagerstown, MD injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or Smithsburg Crematory 4/19/2009 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel S. Man 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) / /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, in any, leading to infine data cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Dealto (or se a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decede at pregnant in the past 12 months? 23d. Date of delivery 1 Live birth 2 Fetal deat 2 Fetal death 3 Ectopic pregnancy Month Day Year 5 Other (specify) P.O. I 1 ☐ Yes 2 No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, <u>۾</u> 4 X Unknown 1 ☐ Ye 2 No 3 Pro bly Completed 24b. Were autops prior to com-death? y findings available letion of cause of 24a. Was a has page 2 s autops After this certificate Division of Vital 1 ∐ Yes 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Manner of Death ate of Injury 28b. Time of 28a. 28c. Injury at Work? 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending investigation ithin 24 hours after death.

the Funeral Director: All ompletely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accide 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicid Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. the 29b. Signature and title of cert 29d. Date signed (Month, Day, Year) 29c. License number 0 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend. Item 9 per FH G890 dk
State of Maryland 7 Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** April 2009 4:21 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 376 Polling House Road Harwood Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Year) Months Days Hours 1 X M 2 □ F DC 218-68-3734 48 11/10/1960 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2/CXNo MD Anne Arundel Harwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 376 Polling House Road 20776 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Specify. ģ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Asst Production Director Printing Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter Hamilton Martin Doris Pean မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Martin 376 Polling House Rd. Harwood, MD 20776 Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2XX remation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 4/10/2009 Glen Burnie, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Annapolis, MD 21401 Approximate Interval Between Onset and Death Immediate Cause (Final hor disease or condition resulting in death) YE ars Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causs (Usease of injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, in 24 hours after death.

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28a-f show

if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

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Examiner

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certificate has been signed by the rector, page 2 should be detached

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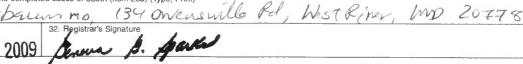
P.O. Box 68760,

/Medical

Pages 1 and 2 should be filed within 72 hours after death with

Baltimore, Maryland 21215-0036

31. Date filed (Month, Day, Year) Registrar



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 1 - State Amended item#16a, 4.8.09, WCHD CSH ficate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Day Year -ou etcher 10:44 -lotter 2009 04 04 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner WICOMI THE 49 If Under 24 Hrs. Hours Min. If Under 1 Year Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□ M 2☑ F Months Days 214-30-8899 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Madical Experiment must be notified at 1 Yes 2 No Director Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 2183 258 Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. <u>Ş</u> Black 3 Widowed 4 Divorced Completed Decedent's Usual Occupation
(Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Group Center Dove 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Health and Mental Thomas ည 777 Dayghta 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mardela South nar 113a5 San Domingo Rol Springs Mo If item ? Saltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 4 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: I any injury o Shurptown 4 Donation 5 ☐ Other (Specify) Cemeter: 4-11-2009 MO 21 Signature of Funeral Service Licensee 22. Name and Address of Facility 917 W. Ferball 601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician URRE /Medical Due to (or as a consequenc of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Directo for as a consequence of The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): P.O. Box 68760, the attending physician Physician/Medical IF FEMALE f yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for L in the past 12 months? Month Vear Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 No detached 9 ☐ Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>Ş</u> director, page 2 should be 1 ☐ Yes 2 K No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a Was an has autopsy certificate 1 ☐ Yes 2 🖪 No 2 No or Attending Physician; Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 POther (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification; To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? After 1 🔀 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: filled in by the 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated

Hospital 24 hours a completely within 2 To the

State Registrar

29b. Signature and title of certifier

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30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

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DHMH 17 Rev 1/2001

29c. License number

29505

:5302 CHINABERRY DR. SALISBURY, MD 21801

29d. Date signed (Month, Day, Year)

04-04-2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Donna M. McGill 6:30 2009 April 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 25668 Nanticoke Road Quantico Wicomico If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Months 1 □ M 2 🔀 F 56 144-44-8235 12/28/1952 New Jersey Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 → No Maryland Wicomico Quantico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 25668 Nanticoke Road 21856 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ∐Yes 2 🗽 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🔀 No Specify Specify: 3 Widowed 4 Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) artist 12 art 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leonard Perfetti Dorothy Sanders 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William McGill/husband 25668 Nanticoke Rd., Quantico, MD 21856 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🙀 Burial 2 ☐ Cremation 3 ☐ Removal from State Parsons Cemetery 4 Donation 5 DOther (Specify) 4/11/09 Salisbury, MD 22. Name and Address of Facility
Holloway Funeral Home Professional Association Service Licensee avid H. (Doughue) 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or combications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 110 -MO disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Questo (presidentes of) If any, reading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Yea Day 5 Other (specify) 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 1 ☐ Yes 2 No 1 ☐Yes 2 ☐No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation (Month, Day, Year) 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

or Attending Physician; The law requires that the death certificate be executed Box 68760, P.0. Division of Vital Records,

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29a, Certifier (Check only one)

29b. Signature and title of certifier

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Funeral

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
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Examiner

Baltimore, Maryland 21215-0036

To the Hospital within 24 hours a To the Funeral C completely filled

State Registrar

MALYO 30 Name and address of perso Joseph

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

who completed cause of death (Item 23a) (Type, Print)

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SALISBURY

10507

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene rgierie Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Year 4:10 P **GEORGE** ELTON MASSEY, JR. 12, 2009 April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** McCready Memorial Hospital Somerset Crisfield 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1⊠M 2□F Director 219-03-0445 87 August 13, 1921 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r 28a-f show notified at show Director 1XXYes 2 □ No Maryland Somerset Crisfield 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? an "natural", or items 23a or Medical Examiner must be I 5 Potomac Street 21817 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any Injury or other traumatic event, the Medical Examiner 1 ☑ Yes 2 □ No World If Yes, Give Year or Dates: War II 1 ☐ Never Married 2 ☑ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. 2 Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Rural Mail Carrier <u>US Postal Service</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Elton Massev Eva Byrd 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine Allender (Daughter) P.O. Box 219 - Bellvue, Colorado 80512 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) April 16, 2009 Crisfield, Maryland Sunnyridge Memorial Park 21. Signature of Funeral Service Licensee

Mary Both Bradshaw-Pruitt 22. Name and Address of Facility BRADSHAW & SONS FUNERAL HOME 306 W. Main Street - Crisfield, Maryland 21817 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Immediate Cause (Final disease or condition resulting in death) Dron Physician /Medical Due to (or as a conseque to Examiner Sequentially list conditions Directo for as a consequence off Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 【 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 X No 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a tion Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and the of cortifier 29c. License number 29d. Date signed (Month, Day, Year) 4422 13ARA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (his the 201-Hal 32. Registrar's Signature 31. Date filed (Month. State 4 2009 Registrar

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4	15 44		For State	State of Maryla		artment of I rtificate of		Mental Hy	Brook	009	1336
		_	Registrar 1. Decedent's Name (First, Middle, Last)			tineate of		2. Date of De	Reg. No.		3. Time of Death
	Physici /Medic		Fred R. M	oore				April	12	2009	0125 M
and of	Examin	er	4a. Facility Name (If not institution, give	. 4 1		4b. City, Town, o	or Location of Death	•		nty of Death	
market.			PENINGULA REGIONAL	Medical C	EMTER	SA	lisbury		W	comic	
	Funeral		5. Social Security Number 6. Sex	1 M OFF	rs. last birthday)	If Under 1 Year Months Days	If Under 24 Mrs. Hours Min.	8. Date of Bi	rth a <i>y, Year)</i>	Coun	lace (State or Foreigr try)
	Director		213-24-4030	81	Yrs.			01/16/	1928	Mary	land
	pu »		Usual Residence of Decedent	100	City Town and					1/	0d. Inside City Limits
	shov	_	10a. State 10b. County	100.	City, Town or Lo	ocation				'	1 ☐ Yes 2 X No
	Ba-f	cto	MD Wicomico		Eden						
	다 다 0 2 2	Director	10e. Street and Number			10f. Zip Code			10g. Citizen	of What Coun	try?
	th wi	la l	25361 Collins Wh	arf Road		218	22		US	A	
	72 hours after death with the Maryland natural", or items 23a or 28a-f show disal Examinar I wast be notified at	Funeral	11. Marital Status	 Was Decedent Ever in Armed Forces? 	n U.S. 13.	Was Decedent of	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or N	0- 14. [Race - Americ Black, White, e	
9	after or ite		1 ☐ Never Married 2 Married	1 □Yes 2 No If Yes, Give		1 □Yes 2 No					510.
93	ral",	l by	3 Widowed 4 Divorced	Year or Dates:		12 100 2 2 100	орсону.		Spe	ecify: Whi	te
2-0	72 hc) tec	15. Decedent's Edu (Specify only highest grade	cation		dent's Usual Occu	pation during most of work	ina	16b. Kind o	f Business/Inc	dustry
21	within 7 iene. than "r	Jple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	d)	mg			
21215-0036	d withii giene. er than	Completed	10	none	Fa	rmer			Agric	ulture	
b	al Hygiu other	Be (17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle	e, Maiden Suri	name)	
<u>a</u>	Aents Aents rked tic e	2	Arlington Edward	Moore			Olive Re	nshaw			
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amontant: If item 27 is marked other than "natural", or items 23a or 28a-f show important: If item 27 is marked other than 2000.		19a. Informant's Name/Relationship (Ty Constance Purcel				Wharf Ro				Code)
Baltimore,	in and 2 if Health tem 27 is		20a. Method of Disposition	20	b. Place of Disp	osition (Name of matory or other pla	3	Date	20c. Location	on - City or To	wn, State
2	Pages nent of int: If its iry or o		1 Burial 2 Cremation 3 R			natory or other pize [. Cemete		5/2009	Allan	, Mary	land
₹	permit. Pag Department Important: I any Injury o		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Serve Ligense						ATTEN	, mary	Land
Ba	permi Depa Impo any It		21. Signature of Fulleral Service Liverist	men.			ess of Facility neral Hom				
	Physician /Medical Examiner	U	234. Part 1. Enter the disease, or complished, or heart failure. List only or immediate Cause (Final disease or condition resulting in death)	Due to (oras a con	eath. Do not er	Terthe mode of dy Len Caroli	erset Aveing, such as cardiac	or respiratory	arrest,	Anne,	MD 21853 Approximate Interval Between Onset and Death
8760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a con	cy Ar	tery	D. Beuse	3/2 C	ABG.		
O. Box 6	at the death certific by the attending p tached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ I 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	□ Ectopic pregnar □ Other (specify)	су		23d.	Date of delive Month	ery Day Year
σ.	res that signed b		Part II. Other significant conditions con	ntributing to death but not	resulting in the I	ınderlying cause gi	ven in Part I.	23e. Did	tobacco use o	contribute to th	ne cause of death?
ds	sign d be	d by	ANTIC STAN	P & 5				1 🗆	Yes 2XN	o 3 Prob	ably 4 Unknown
Ö	w require been sistended should be	Completed	1.1								
ec	law las b	pldu	Diabety					24a. Wa auto	opsy	prior to cor	psy findings available mpletion of cause of
Ε.	: The law icate has I page 2 s	Son						per 1 □ Yes	formed? 2 No	death? 1 ☐ Yes	2 □No
Vital Records,	Physician: The rthis certificate hral director, page	Be (25. Was case referred to medical				26. Place of Deal	th (Check only	one)		
/	nysic lis ce direc	To	examiner? 1 ☐ Yes 2 XNo	lospital: 1 Inpatient	2 ER/Outpatie	ent 3 DOA Ot	her: 4 Nursing H	ome 5 Res	sidence 6 🗆	Other (Specif	<i>(y)</i>
of	g Ph er th eral		27. Manner of Death	28a. Date of Injury (Month, Day, Yea	r) 28b. Time (of 28c. Inju	iry at	28d. Describe	how injury oc	curred	· · · · · · · · · · · · · · · · · · ·
ō	nding I tth. :: After e funer	itio	f Natural 5 ☐ Pending 2 ☐ Accident investigation	(World, Day, rea	// Injury		Yes 2 □No				
Division	Il or Attending affer death. I Director: Affer d in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Sp.	At home, farm, si	reet, factory, office			(Street and No own, State)	umber or Rura	ul Route Number,
	To the Hospital or vithin 24 hours after To the Funeral Direction completely filled in birth and the completely filled in	Medical C		sician: To the best of my ner: On the basis of exal and manner stated.							
	To the within To the Compl	Me	29b. Signature and title of certifier			29c. Licer	se number		29d. Date si	gned (Month,	Day, Year)

State

DHMH 17 Rev 1/2001

30. Name and address

ss of person who completed cause of death (Item 23a) (Type, Print)

13363

Physicia /Medic Examin	a
Funeral Director	

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Evan, item in at the motified at any lighty or other traumatic event, I'm Medical Evan, item in at the motified at any lights of the motified at any lights.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi

Division of Vital Records, P.O. Box 68760,

		4 Described Nove	151A. 141-1-11- 1-	- 41					To Date of Dooth	3		O Time of	f Dooth
hysicia	an	1. Decedent's Name		•					Date of Death Month	Day	Year	3. Time of	
/Medic				Maxine R.		April	17	2009	0744	A ^M			
Examin		4a. Facility Name (If	f not institution, giv	re street and number,			4b. City, Town, or	Location of Death	h	4c. Cour	nty of Death		
		45 Fox (Chase Dri	ive			E1kto	n		C	ecil		
uneral		5. Social Security No			je (In yrs. I	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthp	place (State	or Foreign
rector		557-78-96	562	^{1□M 2} X 0 F 5	8	Yrs.	Months Days	riours wiiri.	July 25	, 1950) Mi	nnesot	:a
_		Usual Residence of	Decedent					`					
MOL #		10a. State	10b. County		10c. City	, Town or Lo	cation				1	10d. Inside C	ity Limits
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282	Director	10e. Street and Nun				owar it	10f. Zip Code		10	g. Citizen d	of What Cour	ntry?	-
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ls 2.	Funeral	11. Marital Status	IIIIIIIIK DI	12. Was Decedent	Ever in U.S	S. 13. V	Was Decedent of H		Specify Yes or No-		Race - Americ		
iter	F		ed 2 Married	Armed Forces? 1 ☐ Yes 2 🏋			f Yes, specify Cuba	an, Mexican, Puert	o Rican, etc.)	В	Black, White,	etc.	
0.	þ	3 X Widowed		If Yes, Give			1∐Yes 2∏No	Specify:		Spe	cify: Whi	ito	
tura			15. Decedent's E			16a, Dece	dent's Usual Occup	ation		6b. Kind of	Business/In		
"na	Completed	(Spec	ify only highest gra	ade completed)		(Give	kind of work done	during most of wor				,	
than	Ĕ	Elementary/Secon	ndary (0-12)	College (1-4or	5+)		memaker	-/		Tn	Uar Or	vn Home	
rt in	ပိ	17. Father's Name ((First Middle Last			пс	memaker_	18 Mother's Nan	me (First, Middle, M			VII_ IIOIIIe	3
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arke	ပ္	Wyman La			<u>_</u>	T			et Rosequ				
is п		19a. Informant's Na				19b. Mailir	ng Address (Street	and Number or Ru	ural Route Number,	City or Tov	vn, State, Zij	p Code)	
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r oth		20a. Method of Disp	17	70	20b. P	lace of Dispo emetery, crer	sition (Name of natory or other place	ce) Apri	Date 19,	0c. Locatio	n - City or To	own, State	
ry o			© Cremation 3 ∟ 5 □Other (Specia	Removal from State fy)			s & Co., L	Apr	9	Wes	t Ches	ster,]	PA
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evantural must be natified at once.		21. Signature of Fu	neral Service Lice	nsee	1000	22	Name and Addre	ss of Facility			0.1.01	, ,	
any one				0. 4. TA		H	licks Hom	e for Fur	nerals, P treet. El	.A.	MD C	21921	
		23a. Part 1. Enter th	ne disease, or com	plications that cause	d the death						MD Z	Approximat	te
		shock, or hea	rt failure. List only	one cause on each I	ine.	P.		3.				Interval Be	tween Death
sician		immediate Cause (disease or condition resulting in death)		a. UV	chose	, de	ey					4nkno	wa.
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	L	Sequentially list cor	nditions.	b.	noil t	ache	26					ansa	1620m.
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ysic Je bu	ical			_d									
as th	an/Medical										1		
endir	5	IF FEMALE: 23b. Was decedent	t pregnant	23c. If yes, outcome			☐ Ectopic pregnanc			23d.	Date of deliv	ery	_
d for	sicia	in the past 12 1 ☐ Yes 2 ☐		4 Pregnant			Other (specify)	, у			Month	Day	Year
by the	Phys	9 ☐ Unknown		9 🗆 Unknown									
det	by P	Part II. Other signif	icant conditions	contributing to death I	out not resu	ulting in the u	nderlying cause giv	en in Part I.	23e. Did tob	acco use c	ontribute to t	the cause of	death?
n sign									1 □ Ye	s 2 🗆 No	3 □ Pro	bably 4 📑	Unknown
peel	ete								24a. Was ar	100	Ib Ware aut	opsy findings	susilable
has e 2	d l								autopsy perform	/		ompletion of a	
pag	Completed								1 □ Yes 2	No	1 ☐ Yes	2 🗆 No	
ertifi sctor,	Be	25. Was case referrexaminer?	red to medical						ath (Check only one	?)		Dougle	
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fter t nera	Ë	27. Manner of Deatl	h 5 ☐ Pending	28a. Date of Inj (Month, D		28b. Time o Injury	f 28c. Injui Wor	ry at k?	28d. Describe ho	w injury occ	curred		
r: A	aţic	2 Accident	investigation	n			M 1 🗆	Yes 2□No					
ecto by th	iţi	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e. Place of III	jury - At ho		eet, factory, office		28f. Location (Str City or Town		mber or Rur	ral Route Nur	nber,
I Dir	Certification: To	4 D Homicide		ballaling, e	te. (Speen	y/			Oily or rown	, State)			
nera y fille		29a. Certifier	1 Certifying P	hysician: To the bes	of my kno	wledge, deat	h occurred at the ti	me, date and plac	e, and due to the ca	ause(s) and	manner as	stated.	
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check only one)	2 ∐ Medicai Exa	miner: On the basis and manner s	or examina tated.	tion and/or in	ivestigation, in my	opinion, death occi	urred at the time, da	ate and plac	e, and due t	to the cause(S)
o th	Me	29b. Signature and	title of certifier				29c. Licens	se number	25	d. Date sig	ned (Month,	Day, Year)	
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		OO Name and a '	raulter	completed course of	dooth /lts -	000) /7:	Drint\					1	
		30. Name and addr	ess of person who	completed cause of	DC 1	E fla	St.	Elble	n MD	219	21		
- CL		31. Date filed (Mon	th. Dav. Year)	32. Ren	rar's Signa	ture	7 -1 1	Great V	2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 30 & 31 per DVR g890 4/27/09 TT

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician P M Eileen Elizabeth April 16, 2009 6:16 Moore /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Hagerstown 12806 Oak Hill Ave. Apt. 7 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 🛣 F Yrs. 217-42-7610 89 **Director** Dec. 28, 1919 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ir than "natural", or items 23a or 28a-f show the Modeal Examinar must be mutified at Director 1XYes 2□No MD Washington Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 12806 Oak Hill Ave. Apt.7 21742 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married , o. 21215-0036 1 ☐ Yes 2 📉 No Specify: Specify: 3 X Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) permit, Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Hem 27 Is marked other than any Injury or other traumatic event Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Russell T. Bair Edna E. Hoffman ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn J. Horn/Daughter P.O.Box 343, Rouzerville, PA 17250 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Rest Haven Cemetery 4/20/2009 Hagerstown, MD 22. Name and Address of Facility Rest Haven Funeral Chapel 21. Signature of Funeral Service Licensee S. Man 1601 Pennsylvania Ave., Hagerstown, MD 21742 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one couse on each line. Immediate Cause (Final due to tailure Cancer **Physician** disease or condition resulting in death) /Medical Due to (or a a consequen rerof): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Day 5 ☐ Other (specify) 1 ☐ Yes 2 🗷 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by

or Attending Physician: The law requires that the death certificate be executed after death. P.O. Box 68760, of Vital Records, certificate ierai Director; After th filled in by the funeral Division

COLOU CAMER

Kidney

6 ☐ Could not be

determined

autopsy

28d. Describe how injury occurred

1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

performe 1 ∐Yes 2 XXNo

Other: 4 Nursing Home 5 KResidence 6 Other (Specify)

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No 27. Manner of Death 1 Natural 2 ☐ Accident

Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28a. Date of Injury (Month, Day, Year) 5 ☐ Pending investigation

and manner stated

(ANCER

28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 □ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

3 Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

26. Place of Death (Check only one)

29b. Signature and title of certifier MD 29c. License number D0056714

29d. Date signed (Month, Day, Year) April 17/09

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SAXENA, 1138 Opa Court Hagerstown, MD 21740 PREETI

State Registrar

Be

Medical Certification: To

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Beren S. Jack

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 105 0 /Medical 4c. County of Death 4b. City. Town, or Location of Death Facility Name (If not institution, give street and number) **Examiner** Baltimore niversity of Maryland Medical 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Min. 9/97 1926ar Maryland Months Days Hours XXM 2 F 88 213-18-1948 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mential Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, Ite Medical Evanment must be neithed at 10c. City, Town or Location 10d. Inside City Limits 10b. County Pylesville 1 ☐Yes 2 ☑No Harford Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21132 4821 Rocks Road United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 15€Xes 2 No If Yes, Give Year or Dates: 1942–45 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2XNo Specify: SpecifyWhite þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing Pipe Fitter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth Cantafio Dominick Motto ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21132 Pylesville, MD 4821 Rocks Road Nicholas F. Motto/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial XX remation 3 ☐ Removal from State 4/20/09 Leola, PA Evans Eagle Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 600 Main Street 21. Signature of Funeral Service Licersee Harkins Funeral Home, Inc., Delta, PA Coverte 23a. Part 1. Enter the dis se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Schemic **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ormany Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) s been signed by the should be detached 9 Hinknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>م</u> 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page ; performed? Yes 2 No 2 No 1 ☐ Yes eral Director: After this certific filled in by the funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Yes 2 No 1 Inpatient Certification: To 28b. Time of 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 1 X Natural 5 Pending 1 ☐ Yes investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours a

To the Funeral C

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal (Check only one) and manner stated.

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5.

29b. Signature and title of certifier

Rebecca toweil 31. Date filed (Month, Day, Year)



Greene

DEA AV4176435018988

Baltimore MD 21230

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician 19, 2009 5:51A. Barbara Ellen Morris April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 3502 Gough Street Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Numbe 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🕅 F **Director** 67 217-38-3763 May25,1941 West Virginia Usual Residence of Decedent s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene.
Item 27 is marked other than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evaniner must be polified at X□Yes 2□No Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21224 U.S.A. 3502 Gough Street by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 □Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □ Yes 2 🙀 No Specify: White 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Food Industry 10 Baker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marjorie M. Shreve ဂ္ Clarence Olio Belt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Elaine M. Siebor/Daughter 3502Gough Street, Baltimore, Maryland21224 Pages 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Pages Department of i Important: If its any injury or o ō P Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SacredHeartofJesusCem.4-22-09 Baltimore, Maryland 21. Signature of Funeral Service Licensee Marzullo Funeral Chapel, P.A. 6009Harford Road, Baltimore, Maryland21214 muhail mas 23a. Part 1. Enter the disease, or complicity in sithat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 155 /Medical Due to r as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of) ned by the attending physician detached for use as the buria Box 68760 the death certificate be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 □ Yes 2 □ No 9 Unknown 9 Unknown signed by σ. significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. The law requires 3 Probably 4 Donknown 1 🗌 Yes 2 🔲 No 24a. Was an Were autopsy findings available prior to completion of cause of death? has in by the funeral director, page 2 a autopsy perforn this certificate 1 ☐Yes 2 ☐ No 1 □Yes **Division of Vital** To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔽 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide 29a. Certifier 1 🖺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

State Registrar

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

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Barbara

ORIGINAL

Registrar's Signature

		For	State of Mar	yland / D	epartment of H	lealth and M	lental Hy	giene	00 1000
		State Registrar			Certificate of	Death		Reg. No. 4	09 13361
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Examiner Funeral Director	5. So 21	ocial Security Number 7-44-1020	spice at +	he Cak	e Sali	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da 12/01		of Death OMiCO 9. Birthplace (State or Foreign Country) Maryland
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aryla shov		State 10b. County		Oc. City, Town					10d. Inside City Limits
ith the Mar or 28a-fsl	MIA IMIA	aryland Wicon	nico	Sall	sbury				1 □ Yes 2 🙀 No
death with the Maryland ims 23a or 28a-f show rmust be notified at meral Director	5 10e.	Street and Number 817 Schumaker	Drive		10f. Zip Code 2180	4		10g. Citizen of W	/hat Country?
Fig. 18 of 19 of 1	3	Marital Status ☐ Never Married 2 🔀 Marrie ☐ Widowed 4 ☐ Divorced	12. Was Decedent Eve Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: A C		13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 X No	lispanic Orlgin? (Spe an, Mexican, Puerto I Specify:	ecify Yes or No- Rican, etc.)		e - American Indian, k, White, etc. " white
21215-00 21215-00 ed within 72 hou ygiene. ygiene. t, it a Medical t, it a Medical		15. Decedent's (Specify only highest	Education	16a.	Decedent's Usual Occup	pation	20	16b. Kind of Bu	siness/Industry
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Baltimore, Maryland 21215-003 Bearnit. Pages 1 and 2 should be filed within 72 hours a pagarment of Health and Mental Hygiene. Important: If filen 27 is marked other than "natural"; any injury or other traumatic event, its Medical Example. To Be Completed by		Informant's Name/Relationshi inda Naundorf,	o (Type. Print) /wife	19b.	Mailing Address (Street 817 Schumak	and Number or Rura er Dr., Sa	Route Number	er, City or Town, Y, MD 21	State, Zip Code) .804
Ore of He of He		Method of Disposition		20b. Place of	Disposition (Name of crematory or other place	D D	ate	20c. Location -	City or Town, State
Page ant: If uny o		1 ☐ Burial 2 🙀 Cremation 3 4 ☐ Donation 5 ☐ Other <i>(Spe</i>	L nemovar nom State		ary Cremato		9	Salisbu	ry, MD
Balt permit. Depart Import any inj	21.	Signature of Funeral Service Li	censee	s CFSP	HO110Way 501 Snow	y füneral Hill Rd.	Home Pr	ofession	 nal Associatior D 21804
	23a.	Part 1. Enter the disease, or co shock, or heart failure. List or	omplications that caused the		-				Approximate Interval Between
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/Medical	resu	Iting in death)	Due to (or as a co	onsequence of):	rcinon	C		
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c 68 ertific ing p e as t		EMALE:	- 10						
Division of Vital Records, P.O. Box 68760, or Attending Physician: The law requires that the death certificate be executed after death. Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit errification: To Be Completed by Physician/Medical Examiliantification:	23b.	Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death	3 ☐ Ectopic pregnance	у		23d. Date Mor	e of delivery nth Day Year
IS, P, res that I signed by be detailed by Ph		. Other significant condition	s contributing to death but n	ot resulting in	the underlying cause give	en in Part I.	23e. Did to	bacco use contri	ibute to the cause of death?
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Division of Vital Records, or Attending Physician: The law requires that date death. Director: After this certificate has been signed in by the funeral director, page 2 should be contification: To Be Completed by			· · · · · · · · · · · · · · · · · · ·				autops perfor	sy pi med? d	rior to completion of cause of eath?
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To the Hospital of within 24 hours af To the Funeral Disconpletely filled in Medical Cer		one) 2 Medical Ex	aminer: On the basis of examiner stated	amination and	or investigation, in my o	pinion, death occurre	ed at the time, o	date and place, a	nd due to the cause(s)
5 \$ 5 3X	296.	Signature and (title of certified	In Room	10.10	29c. License	e number	2	29d. Date signed	(Month, Day, Year)
Oxy	30 N	ame and address of person wh	7 11	(ftern 23a) (T	ype, Print)	1072			
State	31. D	ate filed (Month, Day, Year)	Sergynueller 32. Registrar's	Signature	Loastal	rospice	2011	SDUY	(VV)
Registrar		APR 09	2009 Jenus	1.	park				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Angela Noto 2000 /Medical HOC! 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisburu Salisbury Rehabilitation + Nursing Ctr.
5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Wicomic If Under 1 Year | If Under 24 Hrs 7. Age (In yrs. last-birthday) Birthplace (State or Foreign Country) **Funeral** Date of Birth (Month, Day, Year) 1 □ M 2 🗓 F Months Days Hours Min. 149-07-0088 Director 94 4-3-1915 New Jersey Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show If item 27 is marked other than "natural", or items 23a or 28a-f shot or other traumetic event, the <u>Medical Evanter must be notified at</u> Director 1 ☐ Yes 2 No Salisbury Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 200 Civic Avenue 21804 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian and 2 should be filed within 72 hours after ealth and Mental Hygiene.
m 27 Is marked other than "natural", or ite 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 1 □Yes 2X No ģ Specify: 3 X Widowed 4 □ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Textile Seamstress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ Arabella Carmela Mendolia 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 & Department of Health au Important: If item 27 Is any Injury or other trauone. Camille Fico - Daughter 8811 Archid Drive, Delmar, MD 21875 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 X Removal from State 4 □ Donation 5 □ Other (Specify) George Washington Mem 4-11-2009 Paramus, New Jersey 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 21804 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sir ck, or heart failure. List only the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) 1eas /Medical Due to (or as a consequence of): Examiner 00-1 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed burial-transi attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) the 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown certificate has been signed by rector, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 → No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Ves 2 40 1 ☐ Yes 2 ☐ No 1 ☐ Yes After this certific funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 100 Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Watural 5 Pending Injury 2 Accident investigation 1 ☐ Yes 2 ☐ No Director; 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basic of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of cont 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robins H. illiam 200 21804 MiD 31. Date filed (Month gistrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygieneo Reg. No. 2 () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2009 Year **Physician** Month Marie Freyka Neuman 30 10:30 AM March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BERLIN NURSING & REHABILITATION CENTER WORCESTER BERLIN Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Min 1 ☐ M 2 🕱 F 215-07-8722 Yrs. Maryland 06/07/1917 Director 91 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 7 is marked other than "natural", or Items 23a or 28a-f shot traumatic event, the Medical Examinar must be notified at 1 ¥Yes 2 No Director Berlin Worcester Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21811 9715 Healthway Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐Yes 2 🙀 No If Yes, Give Year or Dates: 1 Never Married 2 Married uman, Marie Itimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: white Specify: Be Completed by 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) financial officer banking 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be f nent of Health and Mental Marie V. Vodacek Joseph a. Freyka ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 231 N. Heron Dr., Ocean City, MD 21842 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Heath ar Important: If item 27 is any Injury or other trau Joann N. Wehnert/daughter Neuman, Neuman, Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4/2/09 4 ☐ Donation 5 ☐ Other (Specify) Salisbury, MD Salisbury Crematory nature of Funeral Service Licensee 22H0110Way Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ASCVD /Medical Due to (or as a consequence of): **Examiner** Hypertentis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed the burial-trar Due to (or as a consequence of): Physician/Medical funeral director, page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
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4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes ♣☑No 24a. Was an certificate 1 □Yes **N**O Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other 4 Nursing Home 5 Residence 6 Other (Specify) 1☐ Yes 2☐ No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred **₩** Natural 5 Pending investigation 1 ☐Yes 2 ☐No 2 🗋 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0 63199 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) YOGESH 614 EASTERN SHOPE SALISBURY, HD. ZISO4 VOHEA istrar's Signature State Registrar

Marie

Box 68760,

<u>Р</u>

Division of Vital Records,

			State of Maryland / Department of Health and Mental Hygiene 1 - State State Certificate of Death Registrar Certificate of Death Registrar
	Physic	an	1. Decedent's Name (First, Middle, Last) 2. Date of Death One Noary Month Day Year Month Day Year
	/Medi Exami	al	4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
q	LAAIIII		Coastal Hospice at the Lake Salis bury Wicomico
ı	Funeral Director		5. Social Security Number 216-20-1760 6. Sex 1 7. Age (In yrs. last birthday) 1 M 2 F 81 Yrs. 81 Yrs. 1 Months Days Hours Min. 1 Min.
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
	e Mary 3a-f sho	ctor	Maryland Wicomico Salisbury 1⊠Yes 2□No
	3a or 28	al Dire	10e. Street and Number 200 Riverhouse Dr., Apt. 1 10f. Zip Code 21801 10g. Citizen of What Country? USA
5-0036	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or items 23a or 28a-f show ont, the Medical Exercinar must be notified at	by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No Specify: Specify: White
	be filed within 72 hours ntal Hygiene. ed other than "natural", event, Irc Modic LEM	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Nomemaker 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) homemaker domestic
land	ld be filed ental Hyg ked other ic event,	To Be C	17. Father's Name (First, Middle, Last) William F. Barnes 18. Mother's Name (First, Middle, Maiden Surname) Louise Winkleman
Mary	nd 2 shou alth and M 27 is mar r traumat		19a. Informant's Name/Relationship (Type. Print) William Neary/husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 200 Riverhouse Dr., Salisbury, MD 21801
Baltimore, Maryland 2121	Pages 1 a lent of Hearn tr. If item ry or othe		20a. Method of Disposition 1 Burial 2 **Termation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Salisbury Crematory 4/9/09 Salisbury, MD
Balti	permit. Pages 1 and 2 should be fill Department of Health and Mental H Important: If item 27 is marked ott any injury or other traumatic even once.		21. Signature of Funeral Service Livence 22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Shock, or heart failure. List only one cause on each line. Approximate Interval Between
d	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) Onset and Death Onset and Death
	Examiner		Sequentially list conditions b. Failure to Thrive
	outed Id	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of).
8760,	icate be executed physician and the burial-transit	al Exa	resulting in death) Last Due to (or as a consequence of):
687	rtificate ng phys as the	Medical	IF FEMALE:
.O. Box	Physician: The law requires that the death certific this certificate has been signed by the attending praid director, page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1
rds, P.	quires that en signed b uld be deta	ρ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
Records,	e law requir has been s je 2 should	Completed	24a. Was an autopsy findings available prior to completion of cause of
Vital	ysician; The lis certificate hadrector, page	Be Co	performed? death? 1 Yes 2 No
of V	Physic this ce al direc	<u>۵</u> '	1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence Quother (Specify) 1 SO ICC
ion	fing I. Afte fune	ation	1 Natural 5 Pending (Month, Day, Year) Injury Work? 2 Accident investigation M 1 Yes 2 No
Division	al or Atters a after de I Directo	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	Medical C	29a. Certifier (Check only one)
	To th To th Comp	M	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
	man		3b. Name and address of person who completed cause of death (Item 23a) (Type, Print)
	000		RALSOhoun Bergmueller mp Constal Hospice PO Pax 1733 Salisbun, mp
	Sta Registr	•	31. Date filed (Month, Day, Year) APR 10 2009 32. Segistrar's Signature A. Jane

09-00 Char	lene Faye F		1- For State Cert	delible Ink. Ensure All Copi rtment of Health and Mental H tificate of Death	lygiene 2009	33
Med	Physicia ical Exami		1. Decedent's Name (First, Middle,Last) Charlene Faye Polen		2. Date of Death Month Day April 18, 2009 3. Time of Death 0137 hrs	
			4a. Facility Name (if not institution, give street and number) Anne Arundel Medical Center	4b. City, Town, or Location of Deat Annapolis	h 4c. County of Death Anne Arundel	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. Ia 223-15-5230 1 M 2XF 44	ist birthday) If Under 1 Year If Under 24Hr Months Days Hours Mii Yrs.	Family	
	w any		Usual Residence of Decedent 10a. State 10b. County 10c. City,	Town or Location	10d. Inside Ci	ity Limits
	rryfand 8a-f sho at once	Director	Maryland Anne Arundel D	Davidsonville	10g. Citizen of What Country?	2 <u>A</u> NO
0	the Ma 3a or 28 otified	Dire	975 St. George Barber Rd.	21035	USA	
X /	r death with the Maryland or items 23a or 28a-f show any must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 No	If Yes, specify Cuban, Mexican, Puert	o Rican, etc.) White, etc.	ick,
	ors after fural", tminer	à	Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed)	1 Yes 2 X No specify: 16a. Decedent's Usual Occupation (Give kind of		
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiens. Important if tiem 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Completed		during most of working life. DO NOT use re Customer Service Repre	esentative Printing	
	Baltimore, MD 21215-0036 semit Pages I and 3 should be filed within 7 Department of Health and Mental Hygienten Inten 27 is marked other than injury or other traumatic event, the Medica	Be Co	17. Father's Name (First, Middle, Last) Charles Pogue	18.Mother's Nam Donna	ne (First, Middle, Maiden Surname)	
	212 ould be d Ments s mark ite even	To B	19a. Informant's Name/Relationship (Type, Print)		Rural Route Number, City or Town, State, Zip Code)	
	MD nd 2 sh alth an em 27 i		Paul R. Polen/ Husband 20a. Method of Disposition 20b. F	975 St. George Barbe	er Rd., Davidsonville, MD Date 120c. Location - City or Town, State	2103
	ges la t of He : If ite		1 Burial 2 X Cremation 3 Removal from State	crematory or other place)	Z6/09 Edgewater, MD	
	altim mit. Pa sartmen sortani		4 Donation 5 Other Specify: 21. Signature of Plure all Service Licensee		eorge P. Kalas Funeral Hom	ne
		_	10 lale	2973 Solomons Isl	and Rd. Edgewater, MD 210	37
	Physician 'Medical xaminer		23a. Part I. Enter the disease, or complications that caused the death. failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	zodone intoxication	or respiratory arrest, shock, or heart Approximate Between 0 Dea	nset and
	ted - nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of c. Due to (or as a consequence of d.			
	e executed sian and rial - transi	lical	Xunpended	,28a-f,perME, g891 5/1	1/09 TT	
	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be execut within 24 hours after death. To the Funneral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transmission and the complete of the funeral director.	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregr 1 Live birth 4 Pregnant at time of deady	2 Fetal death 3 Ectopic pregi	pancy 23d. Date of delivery Month Day	Year
	Records, P.O. Box The law requires that the death cate has been signed by the atte page 2 should be detached for u	٥	Part II. Other significant conditions contributing to death but not re	esulting in the underlying cause given in Part I.		Inknown
	Records The law requirented that has been page 2 should	Completed			24a. Was an autopsy findings prior to completion of comple	
	ital sician: s certif irector,	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2	26.Place of Death (Chec ER/Outpatient 3 DOA Other Nurs	k only one) sing Home 5 Residence 6 Other:	
	on of V suding Phys ath. rr: After thi he funeral d	tion: To	27. Manner of Death 1 Natural 5 Pending 1 Pending 1 Natural 5 Pending	28b. Time of Injury 28c. Injury at Work? Fd $12:40$ am	28d Describe how injury occurred subject ingested drugs a alcohol	nd
	Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this centif completely filled in by the funeral director.	Certification:	3 X Suicide 6 Could not be 28e. Place of Injury - At ho	ome, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Num or Town, State) 1975 St. Georg Barber Way Davidsoville,	nber, City e MD
	To the Hospital within 24 hours To the Funeral completely filler	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledgene) 2 Medical Examiner: On the basis of examination and manner stated.	ge, death occurred at the time, date and place, and/or investigation, in my opinion, death occurred	nd due to the cause(s) and manner as stated.	
	FSFS	ž	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year))

31. Date filed (Month, Day, Year) APR 22 2009 State Registrar

Margarita Korell MD.

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

ORIGINAL

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

April 18, 2009

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3 Time of Death Day 2009 **Physician** 4:00 P M April 10, Paul Elton Pierce /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Prince George's 2305 Hanover Place Bowie Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) New York Funeral Months Days Hours Min. 1 ☑ M 2 ☐ F 10, Director 64 1945 055-34-9531 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Marylanc 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evar, if are insufficed and note. 10d. Inside City Limits Director 1 TYes 2 □ No Prince George's Bowie MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 20716 2305 Hanover Place 12. Was Decedent Ever in U.S. Armed Forces? 1 M/Yes 2 □ No If Yes, Give Year or Dates: 1964–70 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: by Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Audio/Visual Repair Business Owner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas Dunbar Pierce Lottie Belle Oakley ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2305 Hanover Place Bowie, MD 20716 Emily L. Pierce/wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) W. Arundel Crematory 04/11/09 Odenton, MD 21. Signature of Funeral Service Licer Going Mones Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. C.

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Approximate Interval Between Onset and Death 11 months Immediate Cause (Final disease or condition resulting in death) **Physician** Glioblastoma Multiforme /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the death certificate be executed and burial-trar Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 ☐ Other (specify) □Yes 2□No ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an autopsy performed?
Yes 2 No certificate 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5X Residence 6 Other (Specify) Hospital: 1 Yes 2 No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this after death. i Director: After t 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No completely filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funerail 29a, Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical To the within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Wear Mus April 10, 2009 D47654 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charlotte K. Dean, M.D. 110 Irving St. NW GB10 Washington, DC 20010 31. Date filed (Month, Pay, Year) APR 1 4 2009 Registrar's Signatur State Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Physician Day PARSONS MILDRED T. . 2009 1:00 A <u>April</u> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ATLANTIC REHABILITATION CENTER WORCESTER BERLIN If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 1 M 2 F Months Days Hours Min. 98 217-44-1119 Director MARCH 21, 1911 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show traumatic event, the Medical Examinar must be notified Director 1 □Yes 2X No WORCESTER MARYLAND BERLIN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 21811 USA 11024 ADKINS ROAD 23a Funeral items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ☐ Never Married 2 ☐ Married arsons Mildred 212-0036 ō 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify: ۾ Specify: WHITE 3 Widowed 4 □ Divorced "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 7 Il Hygiene. 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be QUILLEN JOHN ELLIOTT ANNEပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important; If Item 27 is
any Injury or other trau MARGARET P. BUNTING/DAUGHTER 10805 ST. MARTIN'S NECK RD, BISHOPVILLE, MD 21813 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4/8/09 CREMATORY OF DELMARVA DELMAR, DELAWARE 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 23a. Part I. Enter the disease, or complications that caused the deal shock, or heart failure. List only one cause on each line. Po not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burlal-transi resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregrant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) o 1 ☐ Yes 2 ☑ No ned by the 9 Unknown 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ sign be 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No page 2 autopsy perform certificate 1 □ Yes 2 \ No 2 12 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1∐ Yes 2∏ No 1 🔲 Inpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To within 24 hours after death.

To the Funeral Director: After thi completely tilled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural Division 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Mo State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2009 13374

	1- For State Certificate of Death	1337
Physician/ Medical Examiner	Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time Month Day Vear 1. Month Day Vear 1. 1.	e of Death 01 hrs
Medical Examine	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	
•)	Johns Hopkins Bayview Medical Center Baltimore	(a)
Funeral Director	5. Social Security Number 207-58-9816 6. Sex 7. Age (In yrs, last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace Foreign Country) F	
á	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Ir	nside City Limits
d how any	Dallimana 1	Yes 2 No
tith the Maryland 23a or 28a-f show notified at once.	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21218 U.S.A.	
or items 23s	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Ind White, etc.	
s after d	3 Widowed 4 Divorced of Page 1 Yes 2XX No specify: Specify: Specify: Black	
2 hour and under u	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Photographer 16b. Kind of Business/Industry Services	
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica Be Comple	17. Father's Name (First, Middle, Last) Curtis Anthony Pounds Sr 18. Mother's Name (First, Middle, Maiden Sumame) Lydia Louise Williams	
MD 2121(d 2 should be fill the and Mental H in 27 is marked aumatic event, I To Be	19a. Informant's Name/Relationship (Type, Print) Louise Williams (Mother) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co. 7578 Kelly St Pitts Pa 15208	
Baltimore, I permit. Pages I and Department of Healt Important: If item injury or other fra	20a. Method of Disposition 1XXBurial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of cemetery, crematory or other place) Greensburg Cem 20c. Location - City or Town, 4/15/2009 Sharpburg E	
Baltir permit. I Departm Importa	21. Sgnature of Funeral Service Censee 22. Name and Address of Facility Mason Funeral Service 5801 Cleveland Ave Riverdale Md207	; 737
Physician		roximate Interval ween Onset and
/Medical caminer	Immediate Care (Final disease or condition resulting in death) a. Multiple Gunshot Wounds Due to (or as a consequence of):	Death
niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couce	
0, e be executed spician and burial - transit edical Examiner		
0, be execusivision and solurial - tra	UNPENDED AMENDED	
c 6876 certificat ending phr use as the cian/M	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Pregnant at time of death 5 Other (Specify)	Year
O. Box		use of death?
ires that signed the detail	1 Yes 2 No 3 Probably	
ords w requ is been should	24a. Was an 24b. Were autopsy autopsy prior to comple performed? death?	findings available ation of cause of
of Vital Records, ing Physician: The law requires. Ther this certificate has been significate that the Completed in: To Be Completed	performed? death? 1 ✓ Yes 2 No 1 ✓ Yes	2 No
tal Fician:	25. Was case referred to medical asymptotic and the control of the	
of Vi Physi ter this eral din	1. ✓ Yes 2 No	
on c ending ath. or: Af the fun	1 Natural 5 Pending Apr 5, 2009 O406 hrs 1 Yes 2 No Subject shot	
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To with to com	and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Date signed)	ay, Year)
	Thedan M. Try JR., m. J. O.C.M.E. OCME April 6, 2009	
1	30. Name and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State Registrar		

			For State Registrar	State of Maryla	and / I	Department of I		/lental Hy	/giene 2 0	109	1337
	Physici		1. Decedent's Name (First, Middle, L Thelma O'Ret	,				2. Date of De April		9 ^{Year}	3. Time of Death 2:10 PM
0	/Medic Examir Funeral Director		4a. Facility Name (If not institution, g	ive street and number)		Towsor	If Under 24 Hrs.	8. Date of Bi	4c. County	of Death altim 9. Birthp	
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210p	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Evan in the state or neitilised at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 SWidowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 □ Yes ② No If Yes, Give Year or Dates:	n U.S.	13. Was Decedent of If Yes, specify Cub		ecify Yes or No Rican, etc.)	o- 14. Race Black Specify.	e - Americ k, White, e	
$S_{\rm F_1} $ $\mathcal{A}\mathcal{O}_1 $ $\mathcal{A}\mathcal{O}_2 $ $\mathcal{A}\mathcal{O}_3 $ Baltimore, Maryland 21215-0036	d within 72 ho giene. rr than "natui In Moloni	Completed	15. Decedent's E (Specify only highest gi	ducation rade completed) College (1-4or 5+)		Decedent's Usual Occu (Give kind of work done life. DO NOT use retire Supervisor	pation during most of worki	ing	16b. Kind of Bu		ŕ
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	hysician /Medical Examiner		23a. Part 1. Enter the disease, if cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a cons	٤		ing, such as cardiac o	or respiratory a	irrest,		Approximate Interval Between Onset and Death
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76	Sta		30. Name and address of person who DANIEUE DOBLEM 31. Date filed (Month, Day, Year)	completed cause of death (II	tem 23a) (Type, Print)	- Compa	09 B	ALTIMONE	EMO	21204
DHMI	Registra H 17 Rev 1/20	ar	APR 2	7 2009 Senen	~ /	B. faces					
						PRIGINAL					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Day 2009 Year Ptak April 20, Louise Marie 9:20 A M /Medical Facility Name (If not institution, give street and number)
Harford Memorial Hospital 4b. City. Town, or Location of Death Examiner 4c. County of Death Havre de Grace Harford 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 2, 1913 9. Birthplace (State or Foreign 1 □ M 2 🛛 F Months Days Hours Min. 95 565-34-1174 New Jersey Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Harford 1 ☐ Yes 2 No Belcamp 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1315 Cranesbill Ct. #104 21017 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □Yes 2XNo þ Specify: 3 ☑ Vidowed 4 ☐ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Teacher School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Ptak ည Elizabeth Delvecchio 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alexa Ptak (Daughter) 1315 Cranesbill Ct. #104, Belcamp, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Shurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5 ☐ Other (Specify) Parkwood Cemetery 4/24/09 Baltimore, Maryland 21. Signatur 22. Name and Address of Facility
Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the pode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No autopsy performed 1 □ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 ☐ Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined

Examiner P.O. Box 68760

The law requires that the death certificate be executed Division of Vital Records,

has page 2 certificate Hospital or Attending Physician: director within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral

burial-transit signed by the attending physician to detached for use as the buria Certification: To Medical

4 Homicide

31. Date filed (Month, Day,

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Funeral

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ed other than "natural", or items 23a or 28a-f shevent, the Modeal Eventher must be notified

"natural", or

1 and 2 should be filed withi Health and Mental Hygiene. em 27 is marked other than

permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evone.

Physician /Medical

and

Baltimore, Maryland 21215-0036

State Registrar

29b. Signature and title of contifier Sur

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Year Terrence James Quinn, Sr. April 2009 6:45 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5 Fairway Island Grasonville Queen Anne's 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 ★ M 2 □ F 61 214-46-6653 **Director** Washington, D.C. July 15,1947 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If leme 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is itselficed from that he notified as 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 21 No Maryland | Queen Anne's **Grasonville** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 Fairway Island 21638 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2K No Specify: 2 Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Banking Mortgage Broker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John William Quinn ပ Margaret Terese Kenny 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dana Quinn/Wife 5 Fairway Island, Grasonville, MD 21638 Baltimore, 20b. Place of Disposition (Name of Chesapeake) Cremation April 11 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Center 4 ☐ Donation 5 ☐ Other (Specify) 2009 Stevensville, MD 21. Signature of Funeral Service License Fellows, Helfenbein & Newnam Funeral Home, P.A. 106 Shamrock Road, Chester, MD 21619 23a. Part 1. Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Year disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) b Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Property Property: After this certificate has been signed by the attending physician and burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician hed for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 2 1 □Yes 1 ☐Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only on examiner? 1 Yes 2 No Other: 4 Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 5 Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Disath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural 3 ☐ Suicide ccident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Two certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and maintenance.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) within 2 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Staate Rocal #300, Amapolis 32. Registrar's Signature 31. Date filed (Month, Day, Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 4 **Physician** James Edward Reynolds 2009 6:00 A^{M} /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 117 E. Potomac St. APT Brunswick Frederick | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 2/15/1947 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral №** M 2□F 214-48-4299 62 Frederick MD Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County Item 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic event, the Madical Examinar must be existing at 1 X Yes 2 □ No Frederick Brunswick Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 72 hours after death with 117 E. Potomac St. APT 1 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 XYes 2 ☐ No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White ģ 3 ☐ Widowed 4 X Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within : Department of Health and Mental Hygiene. Important: if item 27 is marked other than "say highty or other traumatic event, the Magnetic and place. Elementary/Secondary (0-12) College (1-4or 5+) Retired Carpenter Maintenance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lester Lee Reynolds Sr. Marian Louise Green 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 207, 13th Ave. Julie Reynolds, Daug-In-Law Brunswick Md 21716 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/15/2009 St Marks Cemetery Petersville MD 21. Signature of Funeral Service Licensee 22 Name and Address of Facility John T Williams Funeral Home, Brunswick MD 21716 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocardia Minutes Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transli that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 physician by Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day for in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown detached 9☐ Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. page 2 should be 1 Yes 2 □ No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed his certificate I 1 ☐ Yes 2 ☐ No 2 X No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death Check only one Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No ပို 28a. Date of Injury (Month, Day Year) funeral 28c. Injury at Work? 27 Manner of Deat 28b. Time of 28d. Describe how injury occurred Certification: To the Hospital or Attending Natural 5 Pending within 24 hours after deave.
To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier D43091 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TOLL House Are 801 Zaidi MD Squed 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 13 Registrar

			For State Registrar	State of N	/larylan	-	artment of <i>tificate of</i>		d Mental H	lygien Reg. N	7 11 11 7	13379	
			1. Decedent's Name (First, Middle, Las	st)					2. Date of Month		ay Year	3. Time of Death	
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	Funeral Director		5. Social Security Number 6. S	ex □M2⊠F		Vrs	Months Days		1rs. 8. Date of (Month, 02/09	Day, Year	r) Goul	place (State or Foreign htry) ington, DC	
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	how		10a. State 10b. County		10c. City	y, Town or Lo	cation					0d. Inside City Limits	
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036	al", or	by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Date:			I∐Yes 2⊠No	Specify:			Specify: Whit	P	
21215-0036	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show deal Examinat out be notified at	Completed	15. Decedent's Ed (Specify only highest gra	ducation		16a. Dece	dent's Usual Occu	pation	warking	16b.	Kind of Business/In		
21	within 7 ene. than "r	nple	Elementary/Secondary (0-12)	College (1-4o	r 5+)	life.	kind of work done OO NOT use retire	ed)	WOIKING		. =		
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Ē,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show any Injury or other traumatic event, Its Marical Exprinsar bust by notified any once.		20a. Method of Disposition		20b. P		sition (Name of natory or other pla		Date	_	Location - City or To		
Baltimore,	Pages 1 nent of h ant: If ite ary or of		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		te			i	/14/2009) Br	entwood,	MD	
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Вох	eath certific attending p	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcor	n 2 🗌 Fetal	Ideath 3	Ectopic pregnar	су			23d. Date of deliv Month	ery Day Year	
o.	at the de by the a tached f	Physician/Me	1 □ Yes 2 MiNo 9 □ Unknown	4 □ Pregnan 9 □ Unknow		leath 5L	Other (specify)			-		•	
σ.	res that t signed by be detac		Part II. Other significant conditions of	ontributing to death	but not resu	ulting in the u	nderlying cause g	ven in Part I.	23e. D	id tobacco	use contribute to t	he cause of death?	
rds	quires n sigr ld be	d by							_ 1	□Yes	2 No 3 Pro	bably 4 🗌 Unknown	
000	sw requir s been s s should	olete							24a. V	/as an	24b. Were auto	psy findings available	
of Vital Records,	The law cate has page 2	Completed							p	atopsy erformed? s 2	death?	mpletion of cause of 2 11 No	
ita	iclan: The certificate rector, pag	Be C	25. Was case referred to medical examiner?					26. Place of [Death (Check or				
Ž	hysic this ce al dire	D D	1 Yes 24 No			ER/Outpatier	IL 3 L DOA		g Home 5□ F	esidence	6 X Other (Speci	Asst. Lvng	
	ding Pt I. After th funeral	on	27, Manner of Death 1 ☑ Natural 5 ☐ Pending		njury Da <i>y, Y</i> ea <i>r)</i>	28b. Time of Injury	Wo		28d, Descri	be how inj	ury occurred		
isic	ttend death stor:	icat	2 Accident investigation 3 Suicide 6 Could not be	<u> </u>	Injury - At ho	nme form etr]Yes 2 □No	28f Locatio	n /Street	and Number or Run	al Route Number	
Division	I or Attendater death Director:	Certification:	4 ☐ Homicide determined	building,	etc. (Specify	y)	eet, factory, office		City or	Town, Sta	te)	a riogre regnices,	
_	he Hospital or Attending in 24 hours after death. he Funeral Director: After pletely filled in by the fune		29a. Certifier 1 Certifying Pr	nysiclan: To the be	st of my kno	wledge, deat	n occurred at the	time, date and pl	lace, and due to	the cause	(s) and manner as	stated.	
	To the Hos within 24 h To the Fun completely	Medical	(Check only 2 Medical Exar	niner: On the basi and manner		tion and/or in	vestigation, in my	opinion, death o	ccurred at the til	ne, date a	nd place, and due t	o the cause(s)	
	To the within 2. To the I complet	Σ	29b. Signature and title of certifier					se number			Date signed (Month,	Day, Year)	
	10			oure				3201			1/8/19.		
	B		30. Name and address of person who	completed cause of	of death (Item	n 23a) (Type,				m	Salistan	un eno	
	Sta	to	31. Data filed (Month-Dan Year)	32. Regi	trar's Signat	12 10 ture	0 0111	17107	7 304	15	143119	121804	
	Sta Registr		31. APR 1 4 2009 ar)	were he	· pa	New							

DHMH 17 Rev 1/2001

Thelma Rowe

			For State of Maryland / Department of Health and 1 - Registrar Certificate of Death	a Menta		2009	13380
	Physici	an	1. Decedent's Name (First, Middle, Last)		te of Death	Day Year	3. Time of Death
	/Medic	al	Mary S. Reynolds	Ag.	ci1	5, 2009	08:10A M
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of De Authority Manual Molecula Center Authority Town, or Location of De	_		4c. County of Death	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hours Months Days Hours M.		te of Birth onth, Day, Y		place (State or Foreign
	Director		354-32-4392 15 M 2121 68 Yrs.		²⁸ /19	41 111	inois
	ow st		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			1	0d. Inside City Limits
	a-fsh	ctor	Maryland Wicomico Fruitland				1 X Yes 2□No
	or 28	Director	10e. Street and Number 10f. Zip Code		100	. Citizen of What Cour	ntry?
	s 23a	eral	213 Williams Ave. 21826			USA	
	ter de	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 12. Mas Decedent Ever in U.S. Armed Forces? 1 Yes, specify Cuban, Mexican, Pu	? (Specify Ye uerto Rican, o	es or No- etc.)	14. Race - Americ Black, White,	
93	ral", or	þ	If Yes, Give 1 ☐ Yes 2 🛣 No Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates:			Specify: Wh	nite
215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show int, it is Medical Evarinar must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of v	working	16	b. Kind of Business/Inc	dustry
2121	within ene. than '	Jup	Elementary/Secondary (0-12) College (1-4or 5+) If the DO NOT use retired) administrative assis			medica	.7
2		Be Co			Middle, Ma	iden Surname)	14
/lan	uld be Mental Irked c	To B	Harry Keith Dor	othy 1	Lytle		
Maryland	2 should and Mei is marke aumatic		19a. Informant's Name/Relationship (Type. Print) Donald Reynolds Sr/husband 19b. Mailing Address (Street and Number or 213 Williams Ave.,				Code)
	s 1 and of Health item 27 other to			Date		c. Location - City or To	um Ctata
nor	o = to		1 🔀 Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place)		20	·	
Baltimore,	permit. Pa Departmen Important: any injury once.		4 □ Donation 5 □ Other (Specify) Parsons Cemetery : 4/ 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HOIIOway Funeral	/10/09	D 6	Salisbury	
ñ	any per	8 8	501 Snow Hill Rd	., Sal	lisbur	y, MD 2180	Sociation 4
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card shock, or heart failure. List only one cause on each line.	diac or respi	ratory arres	t,	Approximate Interval Between
in.	Physician		Immediate Cause (Final disease or condition resulting in death) a. Princey Decitored Adenocare	ino	na		2 months
-	/Medical Examiner		Due to (or as a consequence of):				
		ner	Sequentially list conditions, if any, leading to immediate cause. Einler Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):				
	ecuted ind transit	Examiner	Cause (Disease or injury that initiated events				
60,	icate be executed physician and the burial-transit	E E	resulting in death) Last Due to (or as a consequence of):				
68/60,	rificate be executed g physician and as the burial-transit	fedical	d				
×	h cert ending use a	M/u	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy			23d. Date of delive	ery
	ding Physician: The law requires that the death cer. Arer this certificate has been signed by the attendir funeral director, page 2 should be detached for use	Physician/N	1 Yes 2 No 4 Pregnant at time of death 5 Other (specify)			Month	Day Year
7.	Attending Physician: The law requires that the refeath. refeath. After this certificate has been signed by the tuneral director, page 2 should be detached the funeral director.		9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23	e. Did toba	cco use contribute to the	ne cause of death?
cords,	uires 1 signe Id be (d by	Renal Failure		1 ☐ Yes		pably 4 ☐ Unknown
900 900	s beer s shou	Completed		24	a. Was an	24b. Were auto	psy findings available
Ĭ	The Is ate ha bage 2	mo		_	autopsy performe ∃Yes 2¥	d? prior to co death? 1 ☐ Yes	mpletion of cause of
VITAL	cian: ertific ector,	Be	25. Was case referred to medical examiner?			(III)	
6	Physi this o	၉	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing			ce 6 ☐ Other (Specif	y)
0	ding th. : After fune	tion	27. Manper of Death 1 ★ Natural 5 □ Pending (Month, Day, Year) 2 □ Accident investigation 28a. Date of Injury (28b. Time of Injury Work? 1 □ Yes 2 □ No	28d. De	escribe now	injury occurred	
VISION	Atten er deal ector: by the	ifica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office	28f. Loc	cation (Stree	et and Number or Rura	I Route Number,
5	ital or rs afte al Dir led in	Certification:			y or Town, S		
:	Hosp 24 hou Funel	Medical	29a. Certifier (Check only one)	lace, and due occurred at th	e to the cau ne time, date	se(s) and manner as s e and place, and due to	tated. the cause(s)
	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fun	Mec	and manner stated. 29b. Signature and title of certifier 29c. License number		29d	. Date signed (Month,	Day, Year)
) of fat M.D 030690	0	A	nr.150	9009
	Kdr		30. Name and oldress of porson who completed cause of death (Item 23a) (Type Print)				
	V		Jones E. MAZTIN Mp. 100 E. Garrell St. 31. Date filed (Monte Barry 18 2009) 32. Jegistrar's Signatury.	5.1	1560	7, MD	>
	Sta Registra		31. Date filed (Month PR 10 8 2009) 32. Jegistrar's Signatury.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. and #11 & 19a.perFh G890 4/2//09 TT State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. / 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Jack B. Rippeon 4-20-2009 :25 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6841 Plantation Road Frederick Frederick | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Year) | Min. | March 14, 1 5. Social Security Number 9. Birthplace (State or Foreign Country)
Maryland 7. Age (In yrs. last birthday) **Funeral** Months 214-34-9694 72 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Evanther must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 XNo MD Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21701 6841 Plantation Road **USA** Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White etc. 72 hours after 1 Never Married 2 Ma Baltimore, Maryland 21215-0036 1 □Yes 2 💆 No If Yes, Give Year or Dates: 156-158 ģ Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Salesperson Farm Equipment Sales permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygis Important; If item 27 is marked other I any injury or other traumatic event, II 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ <u>Frank L. Rippeon</u> Virgie M. Nusbaum 19a. Informant's Name/Relationship (Type. Pritiompanion 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norene St. Clair / Wife 6841 Plantation Road, Frederick, Maryland 21701 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Olivet Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ⚠ Other (Specify) Entombment Frederick, Maryland 21. Signature of Funeral Service Licensee Keeney and Address Basiord PA Funeral Home. MO1473 106 East Church St, Frederick, Maryland 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Box 68760 physician Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Ye ar 5 Other (specify) ed by the a o 9 Unknown 9 Unknown <u>م</u> Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Completed 1 ☐ Yes 2 ☐ № 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page To the Hospital or Attending Physician: The performed 1 ☐Yes 2 ☐ No 1 □Yes 2 NO funeral director, 25. Was case referred to medical Certification: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 25 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manny of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Vatural 5 Pending investigation r death. 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Tipertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier , and 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kanan Hu Thomas Johnson Drive, Suite Month. Dav. Year) 32. Progistrar's Signature 31. Date filed (Month, Day, State Registrar

Samuel Edward Ross, Jr.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2009 133	2	00	9	A14 A15	3	3	8
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		I- For State Registrar			Ce	rtifica	ite of l	Death			Re	g. No.	L. U	0, 00	_
Physici	_	Decedent's Name ((First, Middle,	Last)							Date of Deat Month	h Day	Year	3. Time of Death	٦
ledical Exami	ner	Sa	amuel		Edward	i		Ross, J		/	April 19, 2	009	1637 hrs		
		4a. Facility Name (if n		give street and no	umber)		4b	City, Town, or L	ocation of	f Death		4c. Co.	unty of Dea	th	
		439 Central A					T If I had no	- 04Hrs 6	Data of Bir			irthalaga (State or	ᅴ		
Funeral		5. Social Security Nur	11.6	. Sex	7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Months Days Hours Min.							,	Fore	ign Marvland	
Director		219-02-38	346	1 X M 2 F	2 F 31 Yrs. 07							/1977	ountry)		
7		Usual Residence of D			10c. City, Town or Location									10d. Inside City Limits	
v any		10a. State 10	0b. County		10c. City	y, Iown c							1 X Yes 2 No	- 1	
and shov	5	MD	Alle	egany	Cumberland										3
Aaryland 28a-f show any 1 at once.	Director	10e. Street and Numb	ber	-	10f. Zip Code							0g. Citizen	•		
eath with the Maryland items 23a or 28a-f sho ust be notified at once.		439	Centra	al Avenue	е			215	02				USA	A	
with the ns 23a be noti	eral	11. Marital Status			cedent Ever in U	J.S.		Decedent of Hisp s, specify Cuban,					Race - Ame White, etc.	erican Indian, Black,	
death r ites nust	Fune	1 X Never Married	2 Mar	ried Armed F	2 X No		II TE	s, specify Guban,	MEXICAII,	r dello ra	can, etc./		winte, etc.		
after al", o	by F	3 Widowed	4 Divor	ced If Yes, Give Ye	ar		1 `	Yes 2 X No	specify:				ecify:	White	
136 thin 72 hours a te. than "natura edical Examin		15. Decedent's Edu	cation (Speci	fy only highest gra	de completed)			s Usual Occupations of working life.				16b. Kind	of Business	s/Industry	
6 72 h un "n cal E	Completed	Elementary/Second	dary (0-12)	College (1-4 or 5+)	Ì	Chei		201101		•,	En	iterta	inment	
003 vithin ene.	n d		_				01101		_						_
21215-0036 suld be filed within 7 Mental Hygiene. marked other than it event, the Medica		17. Father's Name (F Samuel	First, Middle, L	ast) Edwai	ad	Ro	oss,			's Name (F enda	irst, Middle, Lee		name)	Johnson	
112 Id be Aental narke	o Be	19a. Informant's Nam	ne/Relationshi					Address (Street	and Num	ber or Rur	al Route Nur	nber. City o	r Town, Sta	te, Zip Code)	\dashv
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Innt: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once	Τo			ss / Moth	ner			Central						21502	
al alt		20a. Method of Dispo						ion (Name of cerr	netery,	[Date	20c. Loca	ation - City	or Town, State	
Baltimore, permit. Pages I a Department of He Important: If ite				3 Removal	from State Cı		ory or othe rland	d Cremat	ory	04/2	1/2009	Cı	umberl	Land, MD	
tir Partiment portan		4 Donation 5 21 Signature of Fund			7					/ am	s Fam	ilv Fu	nera	Home, F.	
Baltimo permit. Pages Department o Important:		41101	6	dam	\checkmark			04 Decat							
Physician		23a. P. rt f. Enter the	diseas, or o	omplications that	caused the deat	th. Do no								Approximate Interva	
/Medical		failure. List only	one cause o	n each line.				bid_obes						Between Onset and Death	d
taminer		Immediate Cause (Fi or condition resulting			a consequence		шот	ord opes	ıcy					+	-0
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ansit		events resulting in de	eath) Last	d											
1760, frcate be executed g physician and s the burial - transit	Physician/Medical	X UNPENDED		AMENDED	23a,27	,per	ME,	g891 5/5	/09	TT					
60, ate be thysic te bur	Mec	IF FEMALE:		23c. If yes	, outcome of pre	egnancy					_	23d. D	ate of deliv	ery	_
587 rrtific ling p	an/	23b. Was decedent property past 12 months?					Fet	al death 3	Ectopio	c pregnanc	су	Mo	onth	Day Year	
Box 68760 e death certificate b the attending physiced for use as the bu	sici	1 Yes 2 No			gnant at time of	death 5	ō Oth	er (Specify)							
, P.O. Box 685 res that the death certific signed by the attending be detached for use as t	h	Part II. Other signifi		9 Olik	nown	. rooultine	a in tha w	adaduina couso c	ivon in De	art I	23e Did	tohacco use	contribute	to the cause of death?	_
P.O.		Part II. Other signili	Cant Condition	ons contributing	to death but not	resum	g in the u	nicerrying cause g	iven in r	ai t 1.				robably 4 🗸 Unknown	n
S, F uires n sign	pa										24a. Was		See and the second	autopsy findings availab	
ords, w requir as been s	E E							13.4			auto	psy		o completion of cause of	
Ceco	Completed by											ormed? 2 ✔ No		Yes 2 No	
Vital Recysician: The list certificate I	ပ	25. Was case referre	ed to medical					26.Place	of Death	(Check on	ly one)				
Vita ysicia his ce direc	To Be	examiner? 1 ✓ Yes 2	No	Hospital: 1	Inpatient 2	ER/O	utpatient	3 DOA	Other ₄	Nursing	Home 5	Residence	e 6 🗸 Ot	her: Scene	
Division of Vital Records, rat or Attending Physician: The law requiring a forecards. a) Directorath. In Director, After this certificate has been is led in by the funeral director, page 2 should 1		27. Manner of Death		28a. Dat	e of Injury hth, Day,Year)	28b.	Time of Ir	njury 28c. Injur	ry at Work	(? 2	8d. Describe	how injury	occurred		
Sion attendia death. ctor: /	ţį	1 X Natural	5 Pendi	ng	,			11	es 2	No					
/iSi r Att ter de virect n by	lig Lig	2 Accident 3 Suicide		igation 28e. Pla	ace of Injury - At	home, fa	arm, stree	t, factory, office b	uilding, e	tc. 2	8f. Location or Town,		Number or	Rural Route Number, Cit	ty
Divis ospital or / hours after ineral Dire	Certification:	4 Homicide		mined (Specif	v)					1	Or TOWN,				
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certi within 24 hours after death. Whe Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as											nanner as s	tated.			
To the II. within 24 To the Fi	Medical			and manner	s of examination stated.	and/or i	nvestigati				tne time, date				
	ž	29b. Signature and ti	title of certifier	,,	7			29c. Licens				1		Month, Day, Year)	
		Mb.	Die	mel /1	NA			0.C.I	M.E.			April 20, 2009			
ζ.		30. Name and addre													
1		Melissa Bras	ssell, MD		ledical Exam			enn Street, B	altimor	e, MD 2	1201				
State 31. Date filed (Month, Day, Year) Registrar APP 27 2009 32 Registrar's Signatur															
						- 7	19								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 4 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Mildred H. Shelley 10, April 2009 2:10a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Westminster Dove House Carroll If Under 1 Year | If Under 2 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🔀 F Yrs 87 6/15/1921 Director 226-19-2956 VA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. Count fshow ? is marked other than "natural", or items 23a or 28a-f shot traumatic event, the Modical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MO Baltimore Hampstead 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21074 19511 Grave Run Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after Hygiene. 1 ∐Yes 2 No If Yes, Give 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 № No white ģ Specify: 3 ₩ Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 <u>insurance sales</u> insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be fi Sallie Williams Giles W. Hodges 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 sh ment of Health and ant: If item 27 is n Victoria A. Rollins, daughter 19511 Grave Run Rd., Hampstead, Md. 21074 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Pages
Department of
Important: If it
any Injury or c 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Carroll Cremation 4/13/2009 Hampstead, Md. 21074 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility M 00741 Eline Funeral Home 934 S. Main Street, Hampstead, Md. 21074 demmer 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause or Lach line. Approximate Interval Between Onset and Death Immediate Cause (Final neumony **Physician** disease or condition resulting in death) BURA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last uence of): Examiner death certificate be executed as the burial-transi ement and Due to (or as a consequence of) Box 68760. physician Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Por Month Day Year 5 Other (specify) signed by the a 0 1 Tyes 2 NAM 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed реел 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 s autopsy performed? death? this certificate 1 ☐ Yes 2 ☐ 1 ☐ Yes 2 Ne Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Dother (Specify) ٩ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 27. Manner eath 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: House Division 1 atural 5 ☐ Pending investigation (Month, Day, Year) 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

WIL 2

> State Registrar

29b. Signature and title

Name and address of person who completed cause of death (Item 23a) (Type, Print)

No. Raman B Kanery 399 Malcalm Drive, West-minute MD 21159 Kaneun -amay 31. Date filed (Month, Day, Year)

32. Registrar's Signature

parke

29c. License number .D = 00 54 218

29d. Date signed (*Month*, *Day*, *Year*)

Registrar

State

3. Registrar's Signature

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

	1	For State Registrar	Oldio o	, marytan	C	e <i>rtifica</i>	ite of L	Death	Mental Hyg	Reg. No.		1338	
ian	ľ	1. Decedent's Name (First, Middle, Last)							2. Date of Dea Month	nth Day	Year	3. Time of Death	
ian cal	L	Robert L. Spice							April	10,	2009	8:10 g	
ner	4	4a. Facility Name (If not institution, give		mber)				Location of Dea	ith	4c. Cou	inty of Death	_	
		Transitions Healtl 5. Social Security Number 6. Se		7. Age (In yrs.	last hirthda		ykesv. ler 1 Year	ILLE If Under 24 Hr	s. 8. Date of Birt		Howai	rd lace (State or Fore	
	Ι.		Z M 2□ F	52	Yrs.	Month		Hours Mir		r, Year)	Cour	itry)	
	-	Usual Residence of Decedent	l						2/3/19	57	I ^v Ič	aryland	
		10a. State 10b. County		10c. City	y, Town or	Location					1	0d. Inside City Lim	
tor		Md. Carroli	L	I I	It. A	irv						1 ☐ Yes 2 ½	
lec	-	10e. Street and Number		· · · · · · · · · · · · · · · · · · ·		10f. 2	Zip Code			10g. Citizen	of What Cour	ntry?	
aiD		7100 Shadyside Dr:	ive				2177	1		USA			
Funeral Director	-	11. Marital Status	12. Was Deci	edent Ever in U. orces?	.S. 1:	3. Was Dec	edent of Hi	spanic Origin? (n, Mexican, Pue	Specify Yes or No- ito Rican, etc.)	14. [Race - Amend Black, White,		
by FL		Never Married 2 Married	1 ☐ Yes If Yes, Gir	ve			2 No	Specify:			ecify:		
		3 ☐ Widowed 4 ☐ Divorced	Year or D	ates:	10= D=					10h Kind a	Whit		
Completed	1	15. Decedent's Edu (Specify only highest grad			(Gi	ve kind of t	sual Occupa vork done d use retired	luring most of w	orking	166. Kind c	of Business/Inc	dustry	
Ĕ		Elementary/Secondary (0-12) 9yrs	College (1-4or 5+)		Disa		,		N	/A		
ø	-	17. Father's Name (First, Middle, Last)			1	DISG	DICC	18. Mother's Na	ame (First, Middle,				
To B		William Spicer S	Sr.					Greta	a Olson				
П	r	19a. Informant's Name/Relationship (Ty	pe, Print)	-	19b. Ma	iling Addre	ss (Street a	and Number or F	Ru <i>ral Route Numb</i> e	r, City or To	wn, State, Zip	Code)	
		William A Spicer 3	Jr./bro	other	710) Sha	dysid	e Drive	Mt. Airy	,Md.2	1771		
1 8	4	20a. Method of Disposition			lace of Dis	position (A	lame of r other place	a)	Date	20c. Locati	on - City or To	own, State	
		1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from	State	-		moria		L4/2009	Marrio	ottsvi]	le.Md.	
	1	21. Signature of Funeral Service Cloens	90						arry H.Wi				
		I Charle (In	note) MOC	0845	4112	old C	olumbia	Pike Ell	icott	City,N	id. 21043	
	T	23a. Part1. Enter the disease, or complishock, or heart failure. List only or	ications that o	caused the death	h. Do not	enter the m	ode of dying	g, such as cardi	ac or respiratory ar	rest,		Approximate Interval Between	
	1	Immediate Cause (Final disease or condition		lunc	1	ar	cer	Y				Onset and Death	
		resulting in death)	Due to	(or as a conseq	uence of):								
		Sequentially list conditions, b. Due to (or as a consequence of):											
Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury												
Cam	1	Cause (Disease or injury that initiated events c. Due to (or as a consequence of):											
	But to (of as a consequence of).												
dical													
lan/Me										Date of delive	en/		
clar	23b. Was decedent pregnant in the past 12 months? 1									Month	Day Year		
Physici	1 Yes 2 No 9 Unknown 9 Unknown												
											contribute to the	ne cause of death?	
d by											o 3□Prob	ably 🐼 Unkno	
eted	24a Mins an 24h W										4b. Were auto	psy findings availa	
Сошр	-									rmed?	death?	psy findings availampletion of cause	
O		25. Was case referred to medical						26 Place of Do	1 ☐ Yes eath (Check only o	22 No	1 🗆 Yes	2 NO	
To B		examiner?	fospital:	Inpatient 2	ER/Outpat	ient 3	DOA Othe	200	Home 5 ☐ Resid		Other (Specif	v)	
on: T	-	27. Manner of Death	28a. Date		28b. Time	of	28c. Injury		28d. Describe h			.,	
atio		Matural 5 ☐ Pending 2 ☐ Accident investigation	(IVIOI)	, way 1 dail)	Injur	M		Yes 2 □No					
Certificati		3 ☐ Suicide 6 ☐ Could not be determined	28e. Place	e of Injury - At ho ling, etc. (Specif	ome, farm,	street, fact	ory, office		28f. Location (S City or Tox		um <i>ber</i> or Rura	I Route Number,	
Cer			Duild	g, -10. (<i>Opeon</i>)	,,				0.1, 0.70	, -1419/			
edicai		29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	ner: On the b	e best of my kno pasis of examina ner stated.	wledge, de tion and/or	ath occurre investigati	ed at the tim on, in my op	ne, date and place pinion, death occ	ce, and due to the curred at the time,	cause(s) and date and pla	d manner as s ce, and due to	tated. the cause(s)	
0		29b. Signature and title of certifier				- 2	29c. License	number		29d. Date si	gned (Month,	Day, Year)	
Σ		16-11					D4	3725	,	41	1210	9	
2	1												
2	-	30. Name and address of person who co	empleted caus	se of death (Item	n 23a) (Typ	e, Print)						1 m a	
N			mpleted caus	2/3	123a) (Typ	e, Print)	Ro	ad V	Veitm	ini	1	40 2115	

Physician /Medical **Examiner Funeral** Director 10a. State

Box 68760 Division of Vital Records, P.O. this certificate

21215-0036

2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 11034M 7009 Hone 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore City The Johns Hopkins Hospital te of Birth If Under 1 Year If Under Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In vrs. last birthday 1 M 2 X Months Days 411-14-1962 46 NY 115-54-4311 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 XNo Director Elkridge MD Howard 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number 21075 Funeral 7817 Grassy Garth 14. Race - American Indian Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 X Never Married 2 ☐ Married Yes 2**X** No 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: Specify Specify: White þ 3 Widowed 4 Divorced 'natural", Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) other than "natu (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Montgomery Co. Schools Special Educator permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If item 27 is marked other 1 any injury or other traumatic event, the once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maryland Be Mary E. Hutton Charles P. Sammis မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7817 Grassy Garth, Elkridge, MD 21075 Denise Chatham / Companion Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 3 Removal from State 1 🗌 Burial Other (Specify) Cremation 4-13-2009
22. Name and Address of Facility Harry H. Ardent Cremation witzke's family Fh, Inc. 21. Signature of Funda nce Licensee M01411 4112 Old Columbia Pike, Ellicott City, MD 21043 de 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Preumono disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death Live birth 3 🗌 Ectopic pregnancy Month Year in the past 12 months? Pregnant at time of death 5 Other (specify) 2 🗌 No Yes 9 Unknown 23e. Did tobacco use contribute to the cause of death? ð 1 Tyes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 2 X No 1 Yes filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) Hospital 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA 1 XInpatient မ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: Injury 1 X Natural 5 Pending 1 🗌 Yes 2 🗌 No investigation 2 Accident To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A 3 Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only one) 29c. License number 29b. Signature and title of certifier F5-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 40 600 North Wolfe St, Baltimore, MD, 21287 32. Registrar's Signature State Registrar lenera

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Baltimore, Maryland 21215-0036

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			For	Please	Type or Prin								_	
			For State Registrar				Cer	tificate	of L	Death		Reg. N	10.0000	10007
	Physici /Medic		1. Decedent's Name		,						2. Date of I Month 04		Pay Year 3 2009	3. Time of Death / 22.24 M
, de	Examin		4a. Facility Name (i	If not institution, giv	e street and number)	je (In yrs. la	et hirthday)	4b. City, T	esd	Location of Deat a If Under 24 Hrs			c. County of Dea	th
	Funeral Director		418-16-3 Usual Residence of	292	M 2□F	8	Vre	Months	Days	Hours Min.	01/17	Day, Yea	7)	bama 10d. Inside City Limits
	the Maryla r 28a-f shov	Funeral Director	MD 10e. Street and Nu	Prince G	eorges		Washi					10g. 0	Citizen of What C	1 Yes 2 □ No
	h with 23a or st bu	al D	11814 Tr	egiovo Pl	ace			2	074	4			USA	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the M-dical Event, nor it ust be notified at once.	by Funer	11. Marital Status	ied 2 X Married	12. Was Decedent Armed Forces? 1 ⊠Yes 2 ☐ If Yes, Give Year or Dates:		3-	Was Decede f Yes, speci I □ Yes 2		ispanic Origin? (S in, Mexican, Puer Specify:	Specify Yes or I to Rican, etc.)	No-	14. Race - Am Black, Whit Specify:	te, etc.
5-0036	2 hour	ted		15. Decedent's Ed	ducation	1940	16a. Deced	ent's Usual				16b.	Kind of Business	lack /Industry
2121	should be filed within 73 and Mental Hygiene. is marked other than "n aumatic event, the Wed	Completed	Elementary/Seco		College (1-4or 8		(Give life. l Posta	DO NOT use	e retired			Fee		Service vernment
pu	be file tal Hi d oth event	Be	17. Father's Name	(First, Middle, Last,)					18. Mother's Na		le, Maide	en Surname)	
Maryland	ould d Mer narke natic	2		ager	Torre Order		401-14-11-		(Chr 4	Lela I	eRamus	-h City	Taura Ctata	Zin Codo)
Ma	d 2 sho Ith and I Ith and I Itaums		Jeffrey S	ame/Relationship (туре. Ртті)					Place I				
ē,	t Health f Health item 27 i		20a. Method of Dis	position			ace of Dispo metery, cren				Date	19.00	Location - City or	
e E	Pages nent of I int: If ite			☐ Cremation 3 ☐ 5 ☐ Other (Specif	Removal from State					ery 04/1	4/2000	P.r.	ntrood	MD
Baltimore,	permit. Page Department of Important: If any Injury of		21. Signature of Fu	uneral Service Licer	nsee	Han	22	. Name and	d Addres		. Linco	oln 1	Funeral	Home, Inc.
	Physician /Medical		23a. Part 1. Evter t shock, or hea Immediate Cause disease or condition resulting in death)	(Final	plications that caused one cause on each li a. Sepsis Due to (or as	3		er the mode	of dyin	ig, such as cardia	c or respiratory	arrest,		Approximate Interval Between Onset and Death
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68760,	eath certificate be executed attending physician and for use as the burial-transit		resulting in death)	Last	Due to (or as	a conseque	ence of):		se .					
O. Box	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was deceden In the past 12 1 □ Yes 2 □ 9 □ Unknown	months? □No	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal	death 3	Ectopic production of the contract of the cont		у		-	23d. Date of de Month	Blivery Day Year
rds, P.	quires that in signed build be deta	by	Part II. Other signi	ficant conditions	contributing to death b	out not resul	ting in the ur	nderlying ca	use give	en in Part I.				o the cause of death? Probably 4½ Unknown
of Vital Records,	sician: The law requir s certificate has been s irector, page 2 should	Completed									pe	as an topsy nformed?	death?	utopsy findings available completion of cause of s 2 □ No
Vita	ician: Sertific ector,	Be (25. Was case referexaminer?		Hospital:				Oth	26. Place of De				
of	ding Phys	.To	1 ☐ Yes 2 ☒ 27. Manner of Deat		1 ☑ Inpati	ent 2 E	R/Outpatier 28b. Time of			4 Li Nursing i			6 ☐ Other (Spi	ecify)
Division	fing After fune	Certification: To	1 ☑ Natural 2 ☐ Accident 3 ☐ Sulcide	5 ☐ Pending investigation 6 ☐ Could not b	(Month, Da	ay, Year)	Injury	М		yes Yes 2 □ No				Rural Route Number,
Div	oital or Attendius after deathurs after deathurs Interctor:		4 Homicide	determined	building, et						City or 1	ōwn, Sta	ate)	
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one)	2 ☐ Medical Exa	nysician: To the best miner: On the basis of and manner st	of examinati		vestigation,	in my o	pinion, death occ		e, date a	ind place, and du	e to the cause(s)
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	Sta Regista		31. Date filed (Mor	2009 Z	32. Regist	rar's Signatu	ire		O E G	0.0250				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Physician 0512 09 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Jown, or Location of Death 4c. County of Death **Examiner** SAUISBUR NICAMICO TENINSULA KEGION AL If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Security Number 6. Sex Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)

5 - 3 1-**Funeral** Days 1 □ M 2 0 F 17 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Director 10g. Citizen of What Country? 10f. Zip Code Street and Number ce Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify. þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Maone. Elementary/Secondary (0-12) College (1-4or 5+) b Or 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be liza ပ္ Imean 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, ate, Zip Code) 19a. Informant's Name/Relationship (Type. Print) (CU)+ annone omoke Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ation 4-13-09 Dove-4 Donation 22. Name and Address of Facility Bennie Smith funeral Home permit. 21. Signature of Juneral Service Licensee 150X 331 POCOMOKO 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) myo cordial **Physician** 10 days /Medical Due to (or as a consequence of): Examiner CWONOUT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of). P.O. Box 68760, cate has been signed by the attending physician page 2 should be detached for use as the buria Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 4 Pregnant at time of death ☐Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 24 hours after death.

Funeral Director: After this certificate 1 ☐ Yes 2 No 2 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a, Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of perfifie 29d. Date signed (Month, Day, Year) 29c. License number Ĉ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) B. Silvia harles wy Keningula 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Strudwick 7:46 PM Fred 2009 Q /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Salisbur Coastal Hospice at Lave Wicomico If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Funeral Months Days Hours 224-14-8833 1 X M 2 □ F 88 Maryland 04/20/1920 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 28a-f show Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be notified at sone. 1 Yes 2 No Director Salisbury Maryland Wicomico 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21804 USA 1109 S. Schumaker Dr., Apt. 225 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Kayes 2 □ No If Yes, Give AirForce Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: white Specify: p 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 12 should be filed within 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) fertilizer company part owner/president 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Fred Nash Strudwick Mary Tilghman ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1109 S. Schumaker Dr., Apt.225, Salisbury, MD21804 19a. Informant's Name/Relationship (Type. Print) Priscilla Strudwick/wife 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4/7/09 Salisbury Crematory Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) anature of Funeral Service Licensee 2.Namiand Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 avid # Compro 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician ere disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** pertensio Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (o as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month. Dav. Year) 29c. License number 29b. Signature

State

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) APR 08 Registrar

Path

(Item 23a) (Type, Print)

		For State Registrar		State of Ma	aryland	-	artment of F <i>rtificate of I</i>	lealth and N Death	_	giene Reg. No. 2	09	13390
Physic /Med		1. Decedent's Name (F		COVEY	SHO	ORT			2. Date of De.	Day	Year 2009	3. Time of Death A 01: 53 M
Exam		4a. Facility Name (If no		street and number)		enter	4b. City, Town, or	Location of Death		4c. County	of Death	· la
Funera Directo		5. Social Security Number 218-16-94	460	x	e (In yrs. Ia 83	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24/Hrs. Hours Min.	8. Date of Bir (Month, Da 09-17	th ay, Year) -1925	Count	ace (State or Foreign ry) Laware
taryland f show	٥		Db. County Wicomic			Town or Lo					10	0d. Inside City Limits 1 □ Yes 2 ŽNo
r 28a-	Director	MD V		0	50	31150	10f. Zip Code			10g. Citizen of V	Vhat Count	ry?
th with	a D	5917 Tap					21801			US		
Dattilliore, IMarylating Z1Z13-0030 permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Heath and Mental Hygiene. Important: If item Z1 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Modical Examination in the inclined and more and any Injury or other traumatic event.	by Funeral	11. Marital Status 1 ☐ Never Married 3 ☐ Widowed 4 ☐	¾ Married	12. Was Decedent Armed Forces? 1 ☑ Yes 2 ☐ I If Yes, Give Year or Dates:	Everin U.S No. 10 1948		Was Decedent of H fYes, specify Cuba I∐Yes 21∑No	ispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	14. Raci Blac Specify	e - America k, White, et	
ithin 72 hound.	Completed	(Specify Elementary/Seconda	5. Decedent's Edu only highest grade ary (0-12)	cation e completed) College (1-4or 5	5+)	(Give life. L		ation during most of work f) ate Tro		16b. Kind of Bu		
filed w Hygie other t		12 17. Father's Name (Fire	st, Middle, Last)			рета	ware sc	18. Mother's Nam	-			,emerre
aryiary should be and Mental s marked o	To Be	Leon Dar	niel Sh	ort				Mary 1	Elizab	eth Hol	llis	
2 short and 1 ls marrauma		19a. Informant's Name	, , ,				,	and Number or Rui			State, Zip	Code)
t and the alth tem 27 sther tr		Jane Sho		ife	20b. Pla	ace of Dispo	sition (Name of		lisbur	20c. Location -		wn, State
calcinion randi. Pages partment of portant: If its portant: If its y Injury or o		1⊠ Burial 2 □ C 4 □ Donation 5	Cremation 3 ☐ F ☐ Other (Specify)	-		lawar	natory or other place e Veter emetery	ans 04/	13/200		Lsbor	co, DE
permit. Departr Imports any Inju	N N	+ 7	Cran	ston			P O Box	n Funera 967, Se	eaford	, DE 19		
Physiciar /Medica Examine		23a. Part 1. Enter the c shock, or heart fa Immediate Cause (Fin disease or condition resulting in death)	ailure. List only or	ications that caused ne ruse on each li Due to (or as	2 A	Stre	er the mode of dyir	ng, such as cardiac	or respiratory a	art t		Approximate Interval Between Onset and Death
icate be executed physician and the burial-transit	al Examiner	Source trails list condition and leading to imme cause. Enter Underlyin Cause (Disease or injust that initiated events resulting in death) Las	ediate ing ury	Due to (or as Due to (or as								
ertificate ing phy	Medical	IF FEMALE:		J								
OI VITAL MECOLOS, P.O. BOX O Physician: The law requires that the death certifi r this certificate has been signed by the attending ral director, page 2 should be detached for use as	Physician/Me	23b. Was decedent proint the past 12 mo	onths?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3 [Ectopic pregnand Other <i>(specify)</i>	у		23d. Dat Mo	te of deliver onth (ry Day Year
w requires that been signed be should be deta	þ	Part II. Other significa	int conditions co	ntributing to death b	out not resul	iting in the u	nderlying cause giv	en in Part I.	23e. Did t			e cause of death? ably 4 Unknown
The law recate has be page 2 sho	Completed								24a. Was autoj perfo 1 🗆 Yes	psy prmed?	Were autop prior to com death? 1 □Yes	osy findings available inpletion of cause of
VICAL F siclan; The certificate rector, pag	Be	25. Was case referred examiner?	- 1	Hospital:			Oth	26. Place of Deat				
Off Of Vital nding Physician: th. After this certifications	n: To	1 Yes 2 No 27. Manner of Death		28a. Date of Inju	iry	28b. Time of Injury	IL 3 LI DOA	y at		dence 6 □Oth how injury occurr)
# Gear	Certification:	2 Accident	5 Pending Investigation 6 Could not be determined	en a				Yes 2 □ No	28f. Location (: City or To	Street and Numb	er or Rural	Route Number,
spital or ours after neral Dir			*Certifying Phy	siclan: To the best				me, date and place			anner as st	ated.
o the Hospital or At nithin 24 hours after d to the Funeral Direct	Medical		Medical Exami	iner: On the basis of and manner st	of examinat			ppinion, death occur			and due to	the cause(s)
oth		30. Name and address	y (Cl	Uyan	teath (Item	1D	Print) 24	4688		April	7,	2009
		31. Date filed (Month,	Li cen	1 gcy, 65	rar's Signati)ees	Pain,	k Dr. S	a 1,55.	y, M	0	71804
Regis	tate trar		APR 08		www	B. ,	barke					

			For State Registrar	State of Maryla		artment of F			iene eg. No.200	9 339
	Physici /Medic		Decedent's Name (First, Middle, Last) James Oliver	Spicer			-	2. Date of Dea Month April 10	Day Yes	3. Time of Death 9:40 AM M
0	Examin		4a. Facility Name (If not institution, give s Wicomico Nursing Ho	ome		Salisbury	r Location of Death		4c. County of D	
	Funeral Director		5. Social Security Number 212-03-2222 6. Sex	M 2□F 92	rs. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day 04/06/I	917	Birthplace (State or Foreign Country) Maryland
	nryland show d at	_	Usual Residence of Decedent 10a. State 10b. County Maryland Wicomic		City, Town or Lo					10d. Inside City Limits 1 X Yes 2 □ No
	with the Ma a or 28a-f s t be notified	Funeral Director	Maryland Wicomic 10e. Street and Number 30970 Wilton Ave			10f. Zip Code 2180)4	1	0g. Citizen of What	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	y Funeral		2. Was Decedent Ever in Armed Forces? 1 X Yes 2 □ No If Yes, Give Arn Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Origin? (Si an, Mexican, Puert Specify:	pecify Yes or No- pecify Yes or No- pecify Yes or No-	14. Race - A Black, W Specify:	merican Indian, 'hite, etc. white
JAMES Spices Baltimore, Maryland 21215-0036	iithin 72 hour ne. han "natural e Medical Ex	Completed by	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation	(Give life. L	dent's Usual Occup kind of work done DO NOT use retired lesman	pation during most of wor d)	king	16b. Kind of Busine	,
Pice and 21	id be filed w ental Hygie ked other ti c event, th	To Be Co	17. Father's Name (First, Middle, Last) Oliver Wood Spice		50.	resilen		ne (First, Middle, i Elizabet	Maiden Surname)	
Mary	nd 2 shoul alth and M 27 is marl r traumati	ř	19a. Informant's Name/Relationship (Ty) Lynn Thomas/daugh	oe. Print) Cer	19b. Mailir 309	ng Address <i>(Street</i> 970 Wilto	and Number or Ru on Ave.,	ral Route Number Salisbur	r, City or Town, Stat Y, MD 218	o Zip Code) 04
Ame Stimore,	Pages 1 a nent of Hea int: If item iry or othe		20a. Method of Disposition 1 【 Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	coul from Chaha		sition (Name of matory or other place Cemetery			20c. Location - City Federalsb	
) 	permit. Departn Importa any Injt		21. Signature of Funeral Service License	land						Association 1804
	Physician and physician and physician and the priral-transit	Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	cequence of):	er the mode of dyll	ng, such as cardiac	VLAPL	PISEAS E	Approximate Interval Between Onset and Death
P.O. Box 68760,	eath certific attending p	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Bc. If yes, outcome pf preg 1 □ Live birth 2 □ Fo 4 □ Pregnant at time o 9 □ Unknown	etal death 3	Ectopic pregnanc	у		23d. Date of Month	delivery Day Year
ords, F	w requires that the d been signed by the should be detached	by	Part II. Other significant conditions cor	tributing to death but not r	resulting in the u	nderlying cause giv	ven in Part I.	23e. Did to		e to the cause of death? Probably 4 Unknown
al Rec	cate has be	Completed						24a. Was a autops perfor	sy prior	
Division or Vital Records,	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has Ampletely filled in by the funeral director, page 2.	Certification: To Be	25. Was case referred to medical examiner? 1 Yes 25 Vo F 27. Man or of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide Could not be determined	ospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year, 28e. Place of Injury - Al building, etc. (Spe	28b. Time of Injury	f 28c. Injui Wor M 1 🗆	ner: 4 Nursing H	28d. Describe h	ence 6 Other (Sow injury occurred	Specify) - Rural Route Number,
_	e Hospital 24 hours a e Funeral etely filled	Medical Co	29a. Certifier (Check only one) 1 Certifying Phys	ician: To the best of my ker: On the basis of examerand manner stated.	knowledge, deatl lination and/or in	h occurred at the ti vestigation, in my o	me, date and place opinion, death occu	, and due to the corred at the time, co	ause(s) and manne date and place, and	r as stated. due to the cause(s)
	To the within 2	Me	29b. Signature and title of certifier	wit	MI	29c. Licens	se number	2	29d. Date signed (M	onth, Day, Year)
_	D. EN		30. Name and address of person who co Mahesha Thimmarayappa M	1.D. 614 Eas	ternshore	Dr Salisbu	ıry MD 2180	4	1//-	
	Sta Registi		31. Date filed (Month, Day, Year) APR 13 2	32. Registrar's Sig	gnature . A	back				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Chrisanne L. Seefried 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Vicamia Conto SS4136114 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day. **Funeral** Year) Days 1 □ M 2 🛂 F 231-66-7929 61 **Director** 1947 New York June 27. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show if Health and Mental Hygiene. Item 27 Is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examinar must by multiful at 1 ☐ Yes 2 TrNo DE Sussex Delmar Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 12949 Twin Acres Lane 19940 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White etc. Pages 1 and 2 should be filed within 72 hours after or the Health and Mental Hygiene. ant: If Item 27 Is marked other than "natural", or ite 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 🔀 Married 1 ☐ Yes 2 🔣 No Specify: ፩ white 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Margaret Shible Frank Leveque, Sr. 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12949 Twin Acres Lane Delmar, DE 19940 Adolf Seefried (Husband) 20a Method of Disnosition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If Its any Injury or o 1 ☐ Burial 2 🛣 Cremation 3 Removal from State Crematory of Delmarva 04-11-2009 Delmar, Delaware 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Short Funeral Home
13 East Grove Street 21. Signature of Funeral Service Licensee Short Delmar, DE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) The law requires that the death certificate be Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 2 4100 1 ☐ Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 1 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Time of 28c. 28d. Describe how injury occurred Injury at Work? 1 Natural 5 Pending ours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours af To the Funeral D completely filled i 1 🗹 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date sinned (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause

SIMONA

Baltimore, Maryland 21215-0036

Box 68760

P.0.

Division of Vital Records,

of death (Item 23a) (Type, Print)

M.D.

32. Registrar's Signature

			For State Registrar		State of Ma	arylani		partme <i>ertifica</i>				ientai Hy	ygien Reg. N	- Z U	09	13	393
	Physici	an		ne (First, Middle, La								2. Date of D		ay \	rear	3. Time of	
-	/Medic			am P. Stul								04 -	05	- 20	09	1:33	5 PM
	Examin	er	1		e street and number)	hal	NVO		y, Town, or					c. County of			
N. Carlotte			5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Bir (Months, De Months Days Hours Min. 7. (Months, De Months) Days Hours Min. 7. (Months, De Months) Days Hours Min. 7. (Months, De Months) Days Hours Min. 7. (Months) Days Min. 7. (Months) Days Min. 7. (Months) Days Min. 7. (Mont											wice			or Foreign
	Funeral Director		214-42-8 Usual Residence o	3436 ¹		64	Yrs	Month			e Min	Month, L June 9	lav Yea	944		ace (State of try) ISY1va	
	land		10a. State	10b. County		10c. City	, Town or	Location							10	Od. Inside Ci	ty Limits
	Mary Ind a	ţ	MD	Wicon	nico	Sa	lisb	ury								1 □Yes	2 🖾 No
	r 283	Director	10e. Street and Nu	mber				10f. Z	Zip Code				10g. C	Citizen of Wh	nat Count	try?	
	th wit		6375 Cer	tennial I	Orive			:	21801					U.S.A			
	rdea	Funeral	11. Marital Status		12. Was Decedent I Armed Forces?	er in U.S	5. 1	3. Was Dec	edent of H	lispanic an, Mexic	Origin? (Spe	cify Yes or N Rican, etc.)	0-	14. Race Black	- America White, e		
5 9 S	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is fredictle Examination in affiling at anone.	by	1 ☐ Never Man 3 ☐ Widowed	ried 2 🛛 Married 4 🗌 Divorced	1 □Yes 2 📉 N If Yes, Give Year or Dates:	No			2 🔀 No	Speci		,		Specify:		ite	
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Mary	id 2 s lith an 27 Is i		Wanda H.		(Wife)		1	Cent								′	
ج و	t and Health tem 27		20a. Method of Dis		(WITE)	20b. PI		sposition (Narematory or				ate		y,MD Location - C	218		
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≥ m	Deparenti Deparenti Impor		Kimi	in Sho	it Dei	vel		Short 13 Eas			Home Stree	t De	1mar	DE	199	40	
			23a. Part 1. Enter	the disease, or com art failure. List only	plications that caused one cause on each lir	the death	. Do not									Approximate Interval Bet	ween
Sing	Physician	Ĥ	Immediate Cause disease or condition	(Final	Heart	cell	Cecla	1	wer	Ca	ercen	Ema	-			Onset and I	
	/Medical Examiner	Н	resulting in death)		Du to (or as	a consequ	ence of):	- 47							- 12		
	xammor	10	Sequentially list co	onditions,	bbut to (or as	B 800025	1010.00										
	nsit	Examiner	cause. Enter Under Cause (Disease or	erlying r injury	Due to (or as	a sonsequ	ence or,										
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68760,	tificate be executed g physician and as the burial-transit	ledical			_d												
			IE ECMALC:									74%	-		- 83	100	
Вох	attending for use	an/I	IF FEMALE: 23b. Was deceder in the past 12		23c. If yes, outcome 1 Live birth			3 ☐ Ectopic	pregnancy	v			1	23d. Date		,	
О. Е	at the dea by the al	Physician/N	1 ☐ Yes 2 ☐ 9 ☐ Unknown	□No	4 ☐ Pregnant at 9 ☐ Unknown			5 Other ((specify)					Mont	n	Day \	/ear
P.0	that thed by detacl				ontributing to death bu	ut not resu	Iting in the	underlyina	r cause give	en in Pai	rt I.	23e. Did	tobacco	use contrib	ute to the	e cause of d	eath?
ds,	uires I sign Id be	d by	10	onara	- 11		9						Yes 2			ably 4∐l	
00	w requir been s	Completed	ae	cheim	en De	en es	ie.	2010				24a. Was	s an	24h We	ere auton	sv findings	available
Re	slcian: The law certificate has t irector, page 2 s	dwc		g cer pre	and the same			-		<u>.</u>		auto	opsy ormed?	de	ath?	sy findings and pletion of c	ause of
<u>ta</u>	an: T	Be C	25. Was case refer	rred to medical						26. Pla	ace of Death	1 ☐ Yes (Check only		lo 1L	Yes :	2 ≱ iNo	
<u>></u>	nysici iis cer direci	To B	examiner? 1 ☐ Yes 2 🔀	No	Hospital: 1 ☐ Inpatie	nt 2 🗆 E	ER/Outpat	tient 3 🗆 [DOA Othe			ne 5□Res		6 ⊠ Other	(Specify	Hee	pieo
0	ding Phys h. After this o funeral dir	Ë	27. Manner of Deal	th 5 ☐ Pending	28a. Date of Inju	ry v. Year)	28b. Time Injur		28c. Injury Work			8d. Describe					
Sio	Attendii death. ctor: A y the fu	catic	2 Accident	investigation 6 □ Could not be				M		Yes 2	□No						
Division of Vital Records,	Hospital or Attending Physician: The law requires that the death cer 24 hours after death. 24 hours after death. 25 hours after death. 36 Hours after death serificate has been signed by the attendir tely filled in by the funeral director, page 2 should be detached for use	Certification:	3 ☐ Suicide 4 ☐ Homicide	determined	28e. Place of Inju building, etc	iry - At hor :. <i>(Specify</i>	me, farm,	street, facto	ory, office		2	8f. Location City or To			or Rural	Route Num	ber,
	pital		29a. Certifier	124 Certifying Ph	nysician: To the best of	of my knov	vledne de	eath occurre	ad at the tin	me date	and place a	and due to the	0 031180	(e) and man	nor se et	ated	
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only one)	2☐ Medical Exam	niner: On the basis of and manner sta	examinat	ion and/o	r investigation	on, in my o	pinion, o	death occurre	ed at the time	, date a	nd place, an	d due to	the cause(s)
	To the haithin 24	ž	29b. Signature and	title of certifier	100	2/2 (2	9c. License	e numbe	er			ate signed (
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	Sta	to	GREG 31. Date filed (Mon	orkio I	M.BELL 32. Registra	050, ar's Signati	ure •	1.530	72 CH (INAB	CKKY	PRIS	AL	SBUR	Y, M	1P 21	100
	Registr		(/	APR 09	2009 Sens	·	B. 1	park									

		•	1 - State of Maryland /		rtificate of L			g. No. 2	009	13394
	Physicia		1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day	Year	3. Time of Death
	/Medic		Stewart Eugene		Scott, Sr		04 -		2009	6:12 AM
	Examin	er	4a. Facility Name (If not institution, give street and number)			Location of Death		1	ounty of Death	
and the second			5. Social Security Number 6. Sex 7. Age (In yrs. last)	hirthday)	If Under 1 Year		8. Date of Birth		9 Birtho	lace (State or Foreign
	Funeral Director		220-26-8490 ¹₽ 74	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 7-7-193	Year) 4	Coun	yland
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, To	own or Lo	cation				10	Od. Inside City Limits
	Maryl	ρ	MD Wicomico W	lilla	rde					1 □Yes 2¶∑No
	r 28a	Director	10e. Street and Number	11114	10f. Zip Code		10	g. Citizer	n of What Coun	try?
	death with the Maryland ims 23a or 28a-f show	a D	7687 Green Lewis Road			21874		US	SA	
	deat	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. \	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Spon. Mexican, Puerto	ecify Yes or No- Rican, etc.)	14.	Race - Americ Black, White, 6	
215-0036	within 72 hours after death with the Marylan then "	by	1 ☐ Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates:		1 □Yes 2X No		,	Sp		ite
ဂ ဂ	72 ho natur lical	eted	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupa	lurina most of worki	na T	6b. Kind	of Business/Inc	lustry
7	within 72 iene. than "na"	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	life. L	DO NOT use retired)		D h	lia Cab	1
7	be filed w ntal Hygie nd other ti event, tra		11 SC	HOOL	Bus Cont	18. Mother's Name	(First Middle N		lic Sch	001
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Mar	. co so =		1,1,1		Green Lew			-		,
ā,	s 1 and 2 of Health item 27 i		20a. Method of Disposition 20b. Place		sition (Name of natory or other place				tion - City or To	wn, State
Ē	Pages nent of ant: If its arry or o		1 Li Buriai 2 Ki Cremation 3 Li Hemoval from State 1		of Delma		2009	De1ma	ar, Dela	aware
Baltimore,	permit. Pages Department of Important: If it any Injury or once.		21. Signature of Euneral Service Licensee	22	2. Name and Addres	s of Facility Bot	unds Fun			
	₽Q = # 9		MILLES - TREET DODG		05 E. Mai				Maryla	
			23a. Png Enter the disease, or complete ons that caused the death. D shock, or heart failure. List only shock as each line.	o not ent	er the mode of dyin	g, such as cardiac	or respiratory arre	est,		Approximate Interval Between Onset and Death
-	Physician		Immediate Cause (Final disease or condition resulting in death)	ape	Demo	entia				
	/Medical Examiner		Due to (or as a consequence	ce (b).	Thai	10				
		ē	Sequentially list conditions, if any, leading to immediate	ne offi:	11111					
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
oʻ	e exec ian an irial-tr	Exa	resulting in death) Last Due to (or as a consequence	ce of):						
P8/P0	rificate be executed g physician and as the burial-transit	ledical	d							
õ ×	ertific ding p		IF FEMALE:	S. 1882						
X Q Q	w requires that the death cer been signed by the attendin should be detached for use	Physician/N	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal der	ath 3[☐ Ectopic pregnancy ☐ Other (specify)	/		230	d. Date of delive Month	ery Day Year
j	the de	ysic	1 Yes 2 No 9 Unknown	11 SL						
J.	that ned b		Part II. Other significant conditions contributing to death but not resulting	g in the u	nderlying cause give	en in Part I.	23e. Did tob	acco use	contribute to the	ne cause of death?
ဥ	requires that the peen signed by th hould be detache	d by					1 ☐ Ye	s 2 🗆 I	No 3□ Prob	ably 4 Unknown
ပ္က	g 2 CI	Completed					24a. Was ai		24b. Were auto	psy findings available mpletion of cause of
ř	sician: The law s certificate has to lirector, page 2 s	mo					perform	ned?	death?	
VItal	sian: ertifica ctor, p	Be C	25. Was case referred to medical examiner?			26. Place of Deat		-	Legisle	4,50
01	thysic this co	To	1 ☐ Yes No Hospital: 1 ☐ Inpatient 2 ☐ ER/			4 □ Nursing Ho	me 5 Reside		Other (Specif	n tospice
Ē	After I	io i	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28l. Matural 5 □ Pending	b. Time of Injury	Work	(?	28d. Describe ho	w injury o	occurred	,
<u>s</u>	ttend death stor:	icat	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home,	farm etr		Yes 2□No	28f. Location (St	root and h	Number or Pum	J Pouto Number
DIVISION	lor A after Direc	Certification:	4 Homicide determined building, etc. (Specify)	, 141111, 311	eet, lactory, office		City or Town		vallibel of Hala	ir House Number,
	To the Hospital or Attending Physician: The Is within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page:	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowler 2 Medical Examiner: On the basis of examination and manner stated.							
	o the vithin ; o the	Med	one) and manner stated. 29b. Signature and title of certifier		29c. Licens	e number	2	9d. Date s	signed (Month,	Day, Year)
	^		Mitte X Im Boronsell	· N	n nau	1645		419	109	
	dut		30. Name appraddress of person who completed cause of death (Item 23	a) (Type,	Print)	<u> </u>		4	101	
	71.7		BHS. Ohma-Begoneller	4	bastal t	tospice	RO BOX	< 17	33 Sc	ilsburym
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	1	rekel	1				/
	Registr	ar	APR 10 2009 A	. 14	B-6, an					

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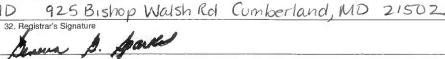
Division or Vital Records, P.O. Box 68760,

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

Wonsock



and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

00055325

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician Sites Ruby /Medical ADO 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Allegany Lions Ctr. for Rehab & Extended Care Cumberland If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | Month, Day, Year | Dec 16, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex Funeral 3, 1916 1 M 2 □ ₹ Months 215-56-8895 92 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. Count 28a-f show traumatic event, the Medical Examiner must be notified at MD Allegany Cumberland Director 1 □¥es 2 □ No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21502 324 Arch Street USA Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 □No **3altimore, Maryland 21215-0036** permit. Pages 1 and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturar", or I any Injury or other traumatic event, the Modical Exampagnes. If Yes, Give Year or Dates Specify Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced white 16a. Decedent's Usual Occupation 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) own home homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Washington Shank Missouri Lucille Shank ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
121 Race Street Cumberland MD 21502 19a. Informant's Name/Relationship (Type. Print) William Sites son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Davis Memorial Cemetery MD Cumberland 4 Donation 5 DOther (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility ral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part J. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cau e (Final disease or condition resulting in deuth) **Physician** Atheroscientic Condio Vascu 2-4-0021 /Medical Due to (or as a consequence of): Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed and-trans Due to (or as a consequence of): attending physician a for use as the burial-Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 No Month Year Day 5 ☐ Other (specify) Ö 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by Nement has been signed by the part of 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 🖾 No 2 🗖 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending s after death.

I Director: Af investigation 1 ☐ Yes 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aff

To the Funeral Di

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number · worrockston D0055325 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

32. Fiegistrar's Signature

Divin B. Jane

925 Bishop Walsh Road Cumberland, md 21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			For State Registrar	State of Ivid	ai yiai iu		tificate of		іменаі пу	Reg. No	2009	13397
	Physici	an	1. Decedent's Name (First, Middle,	wsley					2. Date of De Month April	ath	^y 2009 ^{Year}	3. Time of Death 7:34 P M
-	/Medic Examir		4a. Facility Name (If not institution,	give street and number)				r Location of Deat		4c.	County of Death	7.54 F "
north.	Funeral		10208 Harvest F. 5. Social Security Number 6	. Sex 7. Ag	e (In yrs. lasi		Woodstoc	If Under 24 Hrs	8. Date of Bir		altimore 9. Birthp	place (State or Foreign
	Director		5. Social Security Number 5. Sec 1								40 Ariz	zona
	ryland	_	10a. State 10b. County		10c. City, T	Town or Loc	ation				1	0d. Inside City Limits
	the Ma	recto	MD Baltime	ore	Woods	tock	10f. Zip Code			10a Cit	izen of What Cour	1 ☐ Yes 2 No
	th with 23a or	ral Di	10208 Harvest F.	ields Drive			21163			USA	izon or what oour	m y .
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Event in a rount be muthed in once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:		1	/as Decedent of H Yes, specify Cuba □Yes 2XNo	lispanic Origin? (San, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.))-	14. Race - Americ Black, White, of Specify: Whit	etc.
21215-0036	n 72 ho i "natur edical	Completed by	15. Decedent's (Specify only highest	grade completed)			ent's Usual Occup	oation during most of wo d)	rking	16b. K	ind of Business/Ind	dustry
212	d withii /giene. er than , the M	Comp	Elementary/Secondary (0-12)	College (1-4or 5	+)	LVN/				Hea	althcare	
and	d be file ental Hy ced oth c event	Be	17. Father's Name (First, Middle, La Harry Willis Ch:	*				18. Mother's Nat Pearl J	_{ne (First, Middle)} Ohnson	, Maiden	Surname)	
Baltimore, Maryland	12 shoul h and M 7 Is marl traumati	J.	19a. Informant's Name/Relationship Sherilyn Gibbs/o	(Type. Print)				and Number or R	ural Route Numb		or Town, State, Zip	
ore, I	es 1 and 2 and 4 of Health a fitem 27 is rother train	d	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3				ition (Name of atory or other place		Date		ocation - City or To	
Iţim	nit. Pag artment ortant: I ortury o	- 24	4 □ Donation 5 □ Other (Spe 21. Signature of Funeral Service Lice	cify)	W. A			ory 04/			nton, MD	
Ba	perm Depa Impo any	, Js	Devel It	Felth	MO12						P.O. Box arksville	784 e, MD 21029
IQ.	Dhusisian	2 17	23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final	ly one cause on each lir	ne.	0		α		rrest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as		-	east	Lance	. [1 year
	Examiner	er	Sequentially list conditions,	bto (or as	a consequen	ne (cf):						
	ecuted and transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as								
68760,	rtificate be executed ng physician and as the burial-transit	Medical E		d.	a consequen							
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P.O. Box	t the dea by the a ached fo	Physician/	1 Yes 2 No 9 Unknown	4 □ Pregnant a 9 □ Unknown	t time of deat	th 5 🗆	Other (specify) _				Month	Day Year
rds, F	To the Hospital or Attending Physician: The law requires that the death ce within 24 hours after death. After this certificate has been signed by the attendit completely filled in by the funeral director, page 2 should be detached for use	þ	Part II. Other significant conditions	s contributing to death be	ut not resultin	ng in the und	derlying cause give	en in Part I.	23e. Did t		use contribute to th ✓ No 3□ Prob	ne cause of death? eably 4 ☐ Unknown
3eco	e law re has bee le 2 sho	Completed				· · ·			24a. Was	osy	prior to cor	psy findings available mpletion of cause of
ta	slcian: The certificate h rector, page	Be Co	25. Was case referred to medical	1				26. Place of Dea	1 □ Yes	rmed? 2 No ne)	death? 1 ☐ Yes	2 200
of <	Physici this ce		examiner? 1 ☐ Yes 2 No 27. Manner of Death		nt 2 ER	Outpatient		er: 4 🗆 Nursing H	lome 5 Resi	dence (6 ☐ Other (Specifi	γ)
on	arth. r: After re funer	ation	1 Natural 5 Pending 2 Accident investigat	28a. Date of Inju (Month, Day ion	v, Year)	Injury	28c. Injur Work M 1 🗆	y at <br Yes 2 □ No	28d. Describe	now injur	y occurred	
Division of Vital Records,	after de after de Directo d in by th	Certification: To	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		iry - At home c. (Specify)	, farm, stree	et, factory, office		28f. Location (: City or To	Street an vn, State	d Number or Rura)	l Route Number,
	Hospita 24 hours Funeral etely filler	Medical C	29a. Certifier (Check only one) Certifying 2 Medical Ex	Physician: To the best of aminer: On the basis of and manner sta	f examination	dge, death and/or inve	occurred at the tirestigation, in my o	me, date and place pinion, death occ	e, and due to the urred at the time,	cause(s date and) and manner as s I place, and due to	tated. the cause(s)
	To the within To the compl	Me	29b. Signature and title of contifier		\ i	11.0+	29c. Licens			29d. Dat	te signed (Month,	Day, Year)
			30. Name and address of person wh	regul Cause of de	ACO O	4		56919		0	7/13/09	1
(F) 12		Robert B. Done	egan, M.D. 6	5569 N	. Char		Suite 20)5W Balt	imor	e, MD 212	204
	Sta Registra	le ar	31. Date filed (Month, Day, Year)	2009 32. Régistra	ar's Signature		ake					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Jarman Month Day **Physician** Αм 2009 Frances Jarmon Tilghman 2:00 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 5414 Cherry Hill Lane Wicomico Salisbury If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Hours Min. 1 □ M 2 🗓 F 81 8-11-1927 New York **Director** 083-22-1955 Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits id other than "natural", or items 23a or 28a-f show event, the Medical Exp. it are rough by notified at 1 ☐ Yes 2 No Director Wicomico Salisbury 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21801 5414 Cherry Hill Lane USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. should be filed within 72 hours after nd Mental Hygiene. marked other than "natural", or ite 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify: Specify: White ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Teacher Education permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othr any Injury or other traumatic event. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hammond Jarman ဥ Margaret 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1009 Monitor Court, Salisbury, Maryland 21801 Tilghman - Son Mat 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🏻 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematory of Delmarva: 4-6-2009 Delmar, Delaware 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Mens Menusclewin disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or se a consequence of) Examine The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760. Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy Year in the past 12 months? Month 4 Pregnant at time of death 5 ☐ Other (specify) P.O. 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 1 Yes 2 No 3 Probably 4 Unknown nhumin Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate ha performed? 1 ☐ Yes 2 ☐ No Oster moss 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 Mo Other: 4 Nursing Home 5 PResidence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) After th 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year, 29b. Signature and title of certifier 29c. License number Cyne 6,200 10 mg 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WENRICH RODNEY 1346 S.DIVISION SALISBURY 52.0 31. Date filed (Month, Day, Year) 32. Degistrar's Signature State Registrar

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Funeral Director

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		Vestbury	Dr.			2180	ı				SA	ounity:	
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		lame/Relationsh Villell Villel	a/son —	-		ing Address (Stree 51 Westbu						Zip Code	ə)
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atio	1 ☐ Natural 2 ☐ Accident	5 Pending investigation		th, Day, Year)	Injury	M 1 E	rk?]Yes 2.⊑]No					
ific	3 ☐ Suicide 4 ☐ Homicide	6 Could no determine	ot be 28e. Place	of Injury - At ho	me, farm, st	treet, factory, office			28f. Location (S	treet and	Number or R	Rural Rou	te Number,
Sert	4 LI Normicide		Dullu	ing, etc. (Specify	y)				City or Tow	n, State)			
Medical Certification: To	29a. Certifier (Check only one)	1 Certifying 2 ☐ Medical E	xaminer: On the b	e best of my kno basis of examina oner stated.	wledge, dea tion and/or i	ith occurred at the t nvestigation, in my	ime, date a opinion, de	ath occurr	and due to the red at the time,	cause(s) date and	and manner a place, and du	as stated. e to the c	cause(s)
Me	29b. Signature and	d title of certifier	1 1/		,	29c. Licen	se number		- 2	29d. Date	signed (Mon	th, Day,	Year)
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	30 Name and add	ress of person w	vho completed caus	se of death (Item	23a) (Type	, Print) Salis by	un N	W a	21801				
te	31. Date filed (Mor			egistrar's Signa					1001				
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Vela Welch		State of Maryland / Department of He		/glene 2009	13401
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ical Examii		SARAH VELA WELCH	: T	April 10, 2009 0807	hrs
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Funeral		11.50 4 2 10	Under 1 Year If Under 24Hrs.	8. Date of Birth(MM/DD/YYYY) 9. Birthplace (Str	ate or
Director			onths Days Hours Min.	JULY 26, 1939 Foreign Country WAS	HINGTON, D.
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yland a-f sho	tor	MARYLAND QUEEN ANNE S 10e. Street and Number 100	STEVENSVILLE f. Zip Code	10g. Citizen of What Country?	
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Mail: Fitten 27 is marked offer than "natural", or items 23a or 28a-f she mit. If item 27 is marked offer than "natural", or items 23a or 28a-f she in other traumatic event, the Medical Examiner must be notified at once	Director	102 LITTLE JEAN ROAD	21666	UNITED STATES	
eath with the Maryland items 23a or 28a-f show ust be notified at once.		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was De	cedent of Hispanic Origin? (Sp		, Black,
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3-0030 iled within 72 Hygiene. I other than '	Completed		LITHOGRAPHY	PRINTING	
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T and Health item		20a. Method of Disposition 20b. Place of Disposition	(Name of cemetery,	Date 20c. Location - City or Town, Sta	
rmit. Pages I ar spartment of He portant: If ite		1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: WOODLAWN ME	AP	RIL 15 009 EASTON, MARYLAN	no
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	0 8	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the m	SHAMROCK ROAD.	CHESTER, MAKYLAND 2161	9 imate Interval
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VeCOILDS, IT.O. BOX 80100, The law requires that the death certificate becare has been signed by the attending physicipage 2 should be detached for use as the burit	an/l	23b. Was decedent pregnant in the past 12 months?		ancy Month Day	Year
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The lav	шо			performed? death? 1 ✓ Yes 2 No 1 ✓ Yes	2 No
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tal or Attendir rs after death. al Director: A	icat	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, f	actory, office building, etc.	28f, Location (Street and Number or Rural Route	Number, City
urs aft	Certification:	3 Suicide 6 Could not be 4 Homicide determined (Specify) Major Road / Highway	7	or Town, State) Rt. 50 & Rt. 213, Wye Mills, MD	
To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the f		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred	at the time, date and place, and	diducto the cause(s) and manner as stated.	s)
To the within To the	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	29c. License number	29d. Date signed (Month, Day,	
	Σ	29b. Signature and title of certifier	O.C.M.E.	April 11, 2009	
2		Mayorie melkule			
1995		Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Pen	ın Street, Baltimore, MD	21201	
S	tate	31. Date filed (Month, Day Year) APR 13 2009 32. Redistrar's Signature			
Regis	stra	APR 13 2009 Leners B. Jan	KAN		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 **Physician** Stephen Noll Wolf April 2:00 AM 11, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) Days Hours 11X1M 2□ F 202-36-8601 64 December 4, 1944 Biloxi Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Director Maryland Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5009 40th Place, #405 20781 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Naval Research Laboratory Research Physicist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Raymond A. Wolf Dolores Marie Noll 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5009 40th Place, #405, Hyattsville, MD 20781 Leah R. Wolf / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/15/2009 Gate of Heaven Cemetery Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Euneral Service Licensee Gasch's Funeral Home, P.A. Hyattsville, MD 20781 ems Approximate Interval Between Onset and Death 23a. art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Respiratory Failure Due to (or as a consequence of) Chronic Lymphocytic Leukemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Pancytopenia Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 🗆 Ectopic pregnancy Year Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 2 ☐No 1 ☐ Yes 2 🖾 No Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D66162 4/12/2009 aniedose

Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760, P.O. Division of Vital Records. death. after death

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Experiment 2010.

Physician

/Medical

Examiner

for use as the burial-tran

nding physician

completely filled in by within 24 hours a 20 B State

After t

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Edith Nebuwa Aniedobe,

4 2009 Year)

1500 Forest Glen Road, Silver Spring, MD 20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2009 Month **Physician** 5:00 April 12, Betty Lucille Weaver /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Annapolis Spa Creek Center Anne Arundel If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign
Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, 6. Sex **Funeral** Year) Months Days Hours 1 □ M 2 🖾 F February 12,1921 Buffalo, NY 88 Director 112-14-3645 Usual Residence of Decedent be filed within zerocal strain Hygiene seed other than "natural", or items 23a or 28a-f show and other than "natural", or items 23a or 28a-f show die event, the Medical Examinationals be notified at 10d. Inside City Limits 10c. City. Town or Location 10b. County 1 □Yes 2 X No Anne Arundel Annapolis Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21401 USA 22 Maryland Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 □Yes 2 ☒ No 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Specify. Specify: White 3 Nidowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home n and Mental Hygie 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event once. Be Ottilie Haas William Kehrer ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 1726, Upper Marlboro, MD 20773 Kim Addison / Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4/13/2009 Alexandria, Virginia Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue 23a. Part F. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, smooth of the cause of the caus Hyattsville, MD 20781 Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (as a consequence of): Examiner Sequentially list conditions, if any, leading to firmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last replie Examiner Quality for as a consequence offthe Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and I be detached for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 ☐ Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed certificate has been s rector, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ Ho 1 □Yes 2 ☑No Be 25. Was case referred to medical 26. Place of Death (Check onl one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

To the Funeral Director: After this certific completely filled in by the funeral director, 24 hours a

within 2 To the I 5 B

DHMH 17 Rev 1/2001

State Registrar HUNG . DAMS ,2001 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D53111

29d. Date signed (Month, Day, Year)

09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death **Physician** Lewis LaMar Weiland Month Day Year 0325 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death TENIKSULA REGIONAL 514/5/410 HIBOMICO Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 Maryland 8. Date of Birth **Funeral** 1**☑** M 2□ F Months Days Min 216-18-8869 Hours Yrs. 10/04/1923 85 Director Usual Residence of Decedent 10a, State 10h County 10c. City, Town or Location 28a-f show 10d. Inside City Limits r than "natural", or items 23a or 28a-f shover was be notified at Director 1 X Yes 2 No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 610 Irene Ave. 21801 USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed by 3 Widowed 4 Divorced Specify: white Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) salesman 12 commercial paper co. permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Lewis Weiland Mary Emma Motz ပ 9a. Informant's Name/Relationship (Type. Print) Gladys Weiland/wife 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 610 Irene Ave., Salisbury, MD 21801 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Salisbury Crematory 4/6/09 Salisbury, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Drompron CFSP 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner a vou Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year ed by the detached f 5 Other (specify) signed by the best of the sign Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à COPD 2 No 3 Probably 4 Unknown Completed 1 Tes peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate ひひかとみ 2 🗆 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2 □ No Certification: To Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending tal) 2 Accident investigation 3150109 1 Tyes 2 No after death Director: 0600 filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide GIO Ireve Ave Salis soun 24 hours a Jone Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) within 2 and manner stated 2 29b. Signature and title 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ler, P.O.

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month,

M. ThimmarayADDA MO 100 E. CAITOIL ST.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Wharton orence 04 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HICOMIC Regional MODICAL If Under 1 Year | If Under 24 Ars. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🕱 F 100 21376 1462 9/22/1908 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 20. 1000. 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 ☐ No Completed by Funeral Director Girdletree MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21829 SA 5711 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify. Specify: Black 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 1F-employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hudson ဂ 19a. Informant's Name/Relationship (Type. Print) any ginter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Girdletree Beatrice 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Springs Lucemeter 22. Name and Address of Facility 917 W. Frabella Street 21. Signature of Funeral Service Licensee Bennie Smith tuneral Sociabury 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** In sufficiency Acute Cenonuny disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Month 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by Hereit 1 ☐ Yes 2 ☐ Ho 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an performed' 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated.

Registrar

Clyde Ernest 6,66 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

JR M. D

C. Erset Calin I us. 2.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Snow H. 11, MD 21863 32. Registrar's Signature

29c. License number

00063253

29d. Date signed (Month, Day, Year)

4-6.09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1- State Amended item#18, WCHD, SLU, 4.20 efficate of Death	Reg.	2000 12105
	Physicia		1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Year 9,30 A M
A STATE OF THE PARTY OF THE PAR	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	070	7 2009 9,30 A M
age of the	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 H/s. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birthplace (State or Foreign
ı	Director		Usual Residence of Decedent		924 Couintry) VA
	aryland show	٦٢	10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits 1 ☐ Yes 2 🏋 No
	r 28a-f	irecto	10e. Street and Number 10f. Zip Code	10g.	Citizen of What Country?
	ath with	Funeral Director	29402 Saxis Rd 23442		USH
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertall Hydiene. Important: If fire Z1 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Marical Evancine must be a cilified at once.	þ	11. Marital Status 1 □ Never Married 1 □ Never Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 No If Yes, Specify Cuban, Mexican, Puerto If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify: Specify Cuban, Mexican, Puerto If Yes, Give Year or Dates:	pecify Ye's or No- p Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify:
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/ar√	2 shou h and N is mai raumat		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Run		
Baltimore, Maryland	ss 1 and of Healt item 2		20a. Method of Disposition 20b. Place of Disposition (Name of	0. Poc 357 Date 20c.	Location - City or Town, State
timo	t. Page rtment rtant: If rjury ol		4 Donation 5 Other (Specify) Dirusalan Church Cenetral 411	2009 le	mperance Ville VA
Bal	permi Depar Impor any ir	- 4	21. Sa hature of Funeral Service Licensee 22. Name and Address of Ficility	Home	Galisbury MD SIXI
		. 15	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or fleart failure. List only one cause on each line.		Approximate Interval Between Onset and Death
A street	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Due t, (or as a consequence of):	cident	Shoot and Board
	Examiner	<u>.</u>	Sequentially list conditions, If any, leading to immediate b. Due to (or as a consequence of):		
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ls, P.	uires that the de is signed by the a	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		to use contribute to the cause of death?
ecords,	w requir	leted		1 ∐ Yes 24a. Was an	2 No 3 Probably 4 Unknown 24b. Were autopsy findings available
		Completed		autopsy performed 1 Yes 2	prior to completion of cause of death?
f Vital	Physician: this certific al director,	To Be	examiner? Other:	th <i>(Check only one)</i> ome 5 ☐ Residence	Other (Specify) OSO, C.C.
o uc	Attending Physician: r death. ector: After this certific by the funeral director,		27. Manner of Death 1 → Rending 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Work? 28c. Injury at Work?	28d. Describe how in	
Division of	al or Attendi s after death. al Director; A ed in by the fu	Certification:	3 Suicide 6 Could not be	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
		Medical (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and date	, and due to the cause rred at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)
	To the within To the comple	Mec	29b Signature and title of certifier 29c. License number	29d.	Date signed (Month, Day, Year)
	nav		John Dorgmuell ms D64645	4	17/09
	0 0		30 Name and address of person who completed leause of death (Item 23a) (Type, Print) Atty SONUM-Regnieller MD (dastal tospice PO f	Box 1733	Salsbur mo
	Stat	е	31. Date-filed (Month, Day, Year) 32. Rigistrar's Signature		-

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-02732 Susan Whitaker State of Maryland / Department of Health and Mental Hygiene 2009 1- For State Certificate of Death Reg. No Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Whitaker 1300 hrs Susan Hughes **Medical Examiner** April 6, 2009 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Talbot Easton Easton Memorial Hospital If Under 24Hrs. B. Date of Birth (MM/DD/YYYY 9. Birthplace (State or Foreign If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Maryland Months Hours Min Days Director 71 05/08/1937 M 2XX Yrs 218-34-7907 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 X Yes 2 No "natural", or items 23a or 28a-f show Examiner must be notified at once. Maryland Queen Annes Queenstown Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 128 Governors Way South 21658 USA ra 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14, Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. Funer Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 2 X Married Never Married 2 X No Yes imore, MD 21215-0036

Pages I and 2 should be filed within 72 hours after of nent of Health and Mental Hygiene.

ant: If ieus 27 is marked other than "natural", on onther traumatic event, the Medical Examiner. white Yes, Give Year Specify: Widowed Yes 2 X No specify: Divorced þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 2+ teacher education 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alton Edmund Hughes Marie Stauffer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hugh Whitaker/husband 128 Governors Way South, Queenstown, MD 21658 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Itimore, X Burial 2 crematory or other place) Cremation 3 4/11/09 Salisbury, MD rtant: Parsons Cemetery Other Specify Donation 5 Baltin permit. 22. None and Address frameral Home Professional Association of Forteral Sept ce Licen Depar Impo injur 501 Snow Hill Rd., Salisbury, MD 21804 Approximate Interval Part I. Enter the disease, or complications and cau and the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line /Medical Death a. Multiple Injuries Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (of as a consequence of). events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and Physician/Medical UNPENDED AMENDED ned by the attending physician detached for use as the burial Box 68760 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year Live birth 3 Ectopic pregnancy Month Day Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 ✓ Unknown Unknown 23e. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 V No 3 Probably 4 Completed Records, has been 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? page certificate Yes 2 1 🗸 Yes 2 No 26 Place of Death (Check only one) Division of Vital 25. Was case referred to medical funeral director. Be Hospital: 1 examiner? Other: 2 Y ER/Outpatient 3 Nursing Home 5 Residence 6 Other Inpatient this 1 V Yes No 28a. Date of Injury 28d. Describe how injury occurred 28b. Time of Injury After 27. Manner of Death 28c. Injury at Work? Certification: Drive in auto to tractor-trailer collision Apr 6, 2009 n 24 hours ane week A funeral Director: A 1149 hrs Natural Yes 2 ✔ No Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) Bennett Point Road, Grasonville, MD determined (Specify) Local Street Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. **Medical** To the 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License numbe 29d. Date signed (Month, Dav, Year) 29b. Signature and title of certifier April 7, 2009 O.C.M.E.

State Registra 30. Name and address of

31. Date filed (Month, Day

Pamela E. Southall, MD

Assistant Medical Examiner 32. Registrar's Signature

111 Penn Street, Baltimore, MD 21201

			1 - State Registrar	of Maryland / De	epartment of F Certificate of		d Mental Hy	giene Reg. No. 2	009	1340
	Physici	ian	1. Decedent's Name (First, Middle, Last)				2. Date of De Month		Year	3. Time of Death
-	/Medi	cal	Price Webster 4a. Facility Name (If not institution, give street and	number)	4b. City, Town, o	r Location of D	04	13	2009 Ity of Death	8:00 PM
	Examir	ner	Coastal Hospic - at	the Lake		bury	eatri	1 1	COMIC	6
	Funeral		5. Social Security Number 6. Sex.	7. Age (In yrs. last birtho	Months Days	If Under 24	lin. (Month, D	rth ay, Year)		ace (State or Foreign
	Director		Usual Residence of Decedent	83 Yrs	i. '		03/07/	1926	Mary	land
	yland how		10a. State 10b. County	10c. City, Town or	r Location				10	d. Inside City Limits
	Ba-f s	Director	MD Somerset	Prince	ess Anne					1 □ Yes 2 No
	with the		10e. Street and Number		10f. Zip Code	- 0		10g. Citizen o		y?
	Jeath TIS 23	Funeral	30887 Cooper Lane	ecedent Ever in U.S.	2185		(Specify Yes or No		ISA ace - America	n Indian.
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Menial Hygiene. I health and Menial Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examination and the conditions at	þ	1 Never Married 2 Married 1 XY	Forces? es 2 No Give or Dates: WWII	 Was Decedent of Hard If Yes, specify Cuba 1 ☐ Yes 2 No 	an, Mexican, Pu Specify:	uerto Rican, etc.)	Spec	lack, White, et	c.
ς C	72 ho 'natur	Completed	15. Decedent's Education (Specify only highest grade complete	16a. De	ecedent's Usual Occup ive kind of work done e. DO NOT use retired	pation during most of	workina	16b. Kind of	Business/Indu	
7	within ene. than '	ldmo	Elementary/Secondary (0-12) Colleg	e (1-4or 5+)		d)			•	
ס	filed Hygi other ent,	Be Co	17. Father's Name (First, Middle, Last)	ne	Captain	18. Mother's f	Name (First, Middle		boat ame)	
lan	uld be Venta Irked Itic ev	To B	Clifton Webster			Anna F	lorner			
Maryland	2 sho n and I Is ma rauma	ľ	19a. Informant's Name/Relationship (Type. Print)	19b. M	ailing Address (Street	and Number or	Rural Route Numb	er, City or Tow	n, State, Zip (Code)
	1 and Health em 27 ther t		Flora Jean Webster/Wif		87 Cooper	Lane, F	rincess Date	Anne, M	D_2185	3 Chata
no L	6 O		1 Burial 2 ☐ Cremation 3 ☐ Removal from		sposition (Name of crematory or other place				n - City or Tow	
altimore,	permit. Pag Department Important: I any Injury o		Donation 5 ☐ Other (Specify) 1. lignature of Funeral Service Licensee		1s U.M. Ce 22. Name and Addre Hinman Fun			wenon	a, Mar	yland
ñ	Pe a li	(23a. Part 1. Enter the disease, or complications by	A. M00295	11673 Some	rset Av	e Prine	cess An	ne, MD	21853 Approximate
	Physician ¹	/	shock, or heart failure. List only one cause of	n each line.		1707	11	- /		nterval Between Onset and Death
	/Medical	ľ		to (or as a consequence of):	Ja-Sm	all CE	11 LUX	Can	9	
	Examiner	L	Sequentially list conditions, b.	Imonary I	Emboli			-		
	nsit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	to (or as a consequence of):	Valetos	· W	111 +			
'n	icate be executed physician and the burial-transit	Exar	that initiated events c. Due	to kir as a consequence of):	nabete	2 116		2		
00/0	ate be hysicia he bur	dical	d	typer ten	SION					
0		Med	IF FEMALE:	1 4				Î		
O. DOX	the death certific y the attending p iched for use as	Physician/Me	in the past 12 months?		3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	У			Date of deliver Month D	y Day Year
Jus, F	w requires that the d been signed by the should be detached	by	Part II. Other significant conditions contributing t	death but not resulting in the	e underlying cause giv	en in Part I.	23e. Did			cause of death?
II Records,	The law racate has be page 2 sho	Completed					24a. Was auto perfo 1 □ Yes		prior to com death?	sy findings available pletion of cause of
V I Cal	sician certifi rector	Be	25. Was case referred to medical examiner?		tient 3 🗆 DOA Oth	or:	Death (Check only			
5	g Phys er this eral di): To	27. Manner of Death 28a. Da	☐ Inpatient 2 ☐ ER/Outpa ate of Injury 28b. Time	THE TO DOX	4 LI Nursin	g Home 5 ☐ Resi	how injury occu		tospice
2	nding ath. r: Afte	atio	Natural 5 Pending (Maccident investigation	<i>lonth, Day, Year)</i> Injur	y Worl	ḱ? Yes 2 ∐ No	200. 20001.20	now injury occu	arred	
DIVISION	al or Atte s after des il Directo ed in by th	Certification:	3 Suicide 6 Could not be determined 28e. Pl.	ace of Injury - At home, farm, ilding, etc. <i>(Specify)</i>	street, factory, office		28f. Location (City or To	Street and Nun wn, State)	nber or Rural	Route Number,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: Atter this certificate has completely filled in by the funeral director, page 2 s	Medical (29a. Certifier (Check only one) Certifying Physician: To 2 Medical Examiner: On the and m	the best of my knowledge, do e basis of examination and/o anner stated.	eath occurred at the tir r investigation, in my o	me, date and pl ppinion, death o	ace, and due to the	cause(s) and i date and place	manner as sta e, and due to t	ted. he cause(s)
	To t To t	Σ	29b. Signature and title or certifier	Bezamuell	29c. Licens	e number 4645		29d. Date sign	ned (Month, D.	ay, Year)
		1	30. Mame and a ress of person who completed c	ause of dath (Item 23a) (Typ	pe, Print)	1 1) in Do	D.	7777	C 11-6 -
	Sta	ite	31. Date filed (Month, Day, Year) 32	Registrar's Signature	Cousta	11 102	THE PC	TXX	1133	JANSP4141
	Registr		APR 1 5 2009	Registrar's Signature	pare					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 4-16-09 Physician Year 8:05 PM WILLIAM W)INEBRENNER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death GLENBURNIE HEALTHAND REMARKISTATION ANNE ARUNDE! 8. Date of Birth (Month, Day, Year) Funeral Months Hours Min 215-20-7415 **Director** 10-13-26 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at Yes 2 □ No Director LTIMORE MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? I res 2 No Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married o. Saltimore, Maryland 21215-0036 1 ☐Yes 2 ☑No If Yes, Give Year or Dates: Specify: \$ Specify: WhITE 3 Widowed 4 Divorced 'natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) is marked other than 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) WINEBRENNER Ella CATHERINE SMITH 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a AVE BALTIMORE, MD. 21226 MARJUANE WINEBRENNER, WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of Important: If it any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4-17-09 ODENTON, 4 Donation 5 Dother (Specify) WEST ARUNDE CAEMATORY ervice License DAURNERTY FUNERAL HOME 2601 MOUNTAINAD . PASADENA, MD . 21122 Part 1. Enter the disease of complication shock, or heart failure. List only one call aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Exami Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.0. cate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy this certificate 2 No 1 🗆 Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 **₽** No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) After t 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certif 29d. Date signed (Month. Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

09-03113

Gavin Christopher V	Vood State of Maryla 1-For State Registrar	and / Department o Certificate o	f Health and Mental F f Death	lygiene Reg. I	No. 2009 1340			
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last) Gavin Christopher			2. Date of Death Month Da April 18, 200	3. Time of Death 0925 hrs			
\$	4a. Facility Name (if not institution, give street and not 13 Washington Street		4b. City, Town, or Location of Dea Middletown		4c. County of Death Frederick			
Funeral Director	5. Social Security Number 6. Sex 770-34-9671 1X M 2 F	7. Age (In yrs. last birthday) 4 Yrs	If Under 1 Year If Under 24H Months Days Hours Mi		MM/DD/YYYY) 9. Birthplace (State or Foreign Lorida			
and show any nce.	Usual Residence of Decedent 10a. State 10b. County Maryland Frederick	10c. City, Town or Loca Middleto			10d. Inside City Limits 1 X Yes 2 No			
the Maryland a or 28a-f sh tiffed at onso	10e. Street and Number 13 Washington Street		10f. Zip Code 21769	10g.	Citizen of What Country? U.S.A.			
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 Xi Never Married 2 Married 3 Widowed 4 Divorced If Yes, Give Ye or Dates: 15. Decedent's Education (Specify only highest gra Elementary/Secondary (0-12) College (orces? 2 No 1 de completed) 16a. Deceder during n	as Decedent of Hispanic Origin? (see specify Cuban, Mexican, Puer Yes 2 XNo specify: nt's Usual Occupation (Give kind onost of working life. DO NOT use re	to Rican, etc.) F work done 16	14. Race - American Indian, Black, White, etc. Specify: White bb. Kind of Business/Industry N/A			
215-0036 be filed within 7 mal Hygiene rhed other than ent, the Medica Be Comple	17. Father's Name (First, Middle, Last) Christopher Alan V		18.Mother's Nan	ne (First, Middle, Maid Le Lyn Bil	den Surname)			
MD 2121. d 2 should be fi lith and Mental I lith and unmaric event, To Be	19a. Informant's Name/Relationship (Type, Print) Mr. Sam Billotti III (Grandfather 49	g Address (Street and Number of 952 Flossie Ave.	Rural Route Number	r, City or Town, State, Zip Code)			
Baltimore, permit. Pages I and Department of Heal Important: If iten injury or other tra	20a Method of Disposition 1 X Burial 2 Cremation 3 Removal f	rom State 20b. Place of Dispo	sition (Name of cemetery, ther place) neran Cemetery A	pr. 24, 20	00. Location - City or Town, State 009 Middletown, MD			
Batter Bermit Depart Information Informati	21. Signature of Fun a Service Liver see	MOO255 10 aused the death. Do not enter	Name and Address of Facility Deney and Basfor 106 East Church S The mode of dying, such as cardiac	d PA Fune: t., Frede or respiratory arrest,	rick MD 21701 shock, of heart Approximate Interval			
/Medical xaminer	tra ta' t a a t	/ounds (3) of Head a consequence of):			Between Onset and Death			
aminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last cut to consider the constant of the cause. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last consequence of the cause of							
e be executed ysician and burial - transit	d. UNPENDED AMENDED							
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be ewithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the burnal edical Certification: To Be Completed by Physician/Medi	23b. Was decedent pregnant in the past 12 months?	nant at time of death 5 0	etal death 3 Ectopic preg	nancy	23d. Date of delivery Month Day Year			
s, P.O. iries that the signed by d be detach	Part II. Other significant conditions contributing to	o death but not resulting in the	underlying cause given in Part I.		cco use contribute to the cause of death? 2 No 3 Probably 4 Unknown			
Division of Vital Records, rat or Attending Physician: The law requires as after death. "al Director: After this certificate has been signed in by the funeral director, page 2 should be entification: To Be Completed				24a. Was an autopsy performe				
f Vital Rec Physician: The I ar this certificate and director, page To Be Corr	Tes 2 No	Inpatient 2 ER/Outpatien		sing Home 5 Re	sidence 6 🗸 Other: Scene			
Division of a spital or Attending Phours after death. neral Director: After to filled in by the funeral Certification: T	1 Natural 5 Pending FOUNL Apr 18,	Day, Year) FOUND:	1 Yes 2 ✔ No	28d. Describe how Subject shot	et and Number or Rural Route Number, City			
Divis To the Hospital or A within 24 hours after To the Funeral Bire completely filled in b ledical Certific	Suicide Could not be determined (Specify) 29a Certifier	Single Family		or Town, State 13 Washington S	e) Street, Middletown, MD			
To the Hospital within 24 hours. To the Funeral completely filled	Tolloon only	of examination and/or investiga	rred at the time, date and place, au tion, in my opinion, death occurred 29c. License number	at the time, date and				
	30. Name and address of person who completed cau	se of death (Item 23a)	O.C.M.E.		April 19, 2009			
State		Medical Examiner 11 egistrar's Signature	1 Penn Street, Baltimore,	MD 21201				
Registrar DHMH 17 Rev 1/2001	APR 2.7 2009	origina	AL.					

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lan Wood	State of Maryland / Department of Health and Mental Hygiene
4 Fax State	

Chandler Alan V		Stat	e of Maryland		ent of He		d Mental H		2	2009 134
Physicia		Registrar 1. Decedent's Name (First, Middle, I						2. Date of Dea	eg. No. th	3. Time of Death
Medical Exami	ner		Alan Wood					Month April 18, 2	Day Year 2009	0925 hrs
		4a. Facility Name (if not institution,13 Washington Street					1	4c. County o		
Funeral		760 000107		e (In yrs. last bir		Under 1 Yea		_	th(MM/DD/YYYY)	9. Birthplace (State or
Director			Хм 2 г	5	Yrs. M	onths Day	s Hours Mir	July 8	3, 2003	Foreign Country) Florida
áu	- 1	Usual Residence of Decedent 10a, State 10b, County		10c. City, Towr	or Location					10d. Inside City Limits
and Fshow a	٦	Maryland Frede	rick		dletown					1 X Yes 2 No
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Importment of Health and Mental Hygiene. Important: If time I is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 13 Washington S	treet			. Zip Code 21769		1	0g. Citizen of Wh. U.S.A.	at Country?
h with ems 23	Funeral	11. Marital Status	12. Was Decedent				spanic Origin? (S		- 14. Race White	- American Indian, Black,
er deat	Armed Forces? If Yes, specify Cuban, Mex Armed Forces If Yes, specify Cuban, Mex Armed Forces If Yes,					rtican, etc.)		White		
urs aft toral"	à	Widowed 4 Divorce Divorce 15. Decedent's Education (Specify)	or Dates:	npleted) 16a.			tion (Give kind of	work done	Specify: 16b. Kind of Bus	siness/Industry
5 72 hor in "na	eted	Elementary/Secondary (0-12)	College (1-4 or		during most of	working life	. DO NOT use ref			
Vithin iene.	Compl	K			Stu	dent			Educa	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be	-	r Alan Wood				Franc	ie Lyn H	Maiden Surname) Billotti	
MD 21 d 2 should Ith and Me n 27 is ma numatic en	To	Mr. Sam Billott	i III, Gran	Grandfather 4952 Flossie Ave., Frederick, MD 21703						1, State, Zip Code) D 21703
s land s land sf Heal If item		20a. Method of Disposition 1 X Burial 2 Cremation	3 Removal from St	20b. Place	of Disposition tory or other pl	(Name of ce	metery,	Date	20c. Location -	City or Town, State
Baltimore, Department of the Important: If ite		4 Donation 5 Other Spec	ify:	Zion	Luther	an Cer	netery A	pr. 24,	2009 Mid	ddletown, MD
Balt permit Depart Impor		21. Signature of Funeral Service Lie	//	100255	2k Narn 106	ed Addis East (To Bastor Church S	d PA Fur t., Fred	peral Horick,	MB 21701
Physician /Medical		23a. Part I. Enter the disease, or of failure. List only one cause on	mplications that caused each line.	the death. Do n	ot enter the mo	de of dying,	, such as cardiac	or respiratory arr	est, shock, or hea	Approximate Interval Between Onset and
xaminer		Immediate Cause (Final disease or condition resulting in death)	a. Gunshot Wound		ad					Death
		Sequentially list conditions,	Due to (or as a conse	equence on:						
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a conse	equence of):						
cuted and transit	Exa	events resulting in death) Last	Due to (or as a conse	equence of):						(1
), be exe ician urial -	edical	UNPENDED	AMENDED							
876(inficate ng phys	n/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcor	ne of pregnancy		ath 3	Ectopic pregn	ancv	23d. Date of Month	delivery Day Year
ox 6	Physician/M	past 12 months? 1 Yes 2 No 9 Unkno	4 Pregnant at time of death 5 Other (Specify)					Month	Day 10a	
the dea	Phy	Part II. Other significant condition	9 Unknown	hut not recultir	o in the under	vina cause	given in Part I	23e Did to	phacco use contril	bute to the cause of death?
ords, P.O. B w requires that the d s been signed by the	ā		continuous g to doda	T DOL THOU T COOK	ig in the diden	ying cause	giveirii i ait i.			Probably 4 Unknown
rds, requir	Completed							24a. Was		Vere autopsy findings available
tal Reco	g W		-					autor perfo 1 V Yes	rmed? d	prior to completion of cause of leath? Yes 2 No
al R ian: T entifica ctor, pi	BeC	25. Was case referred to medical				26.Place	e of Death (Check			2 10
of Vit ing Physici After this c	5	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatie		Outpatient 3	DOA	hausen!		Residence 6	
on of tending I sath. or: Afte the funer		27. Manner of Death 1 Natural 5 Pending		FOI	Time of Injury JND: 9 hrs		ry at Work? Yes 2 ✔ No	28d. Describe I Subject sho	how injury occurre t	∍d
Division of Vital Records, P.O. Box 6876(To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the b	Certification:	2 Accident Investig 3 Suicide 6 Could n 4 Homicide determi	ot be 28e. Place of In	jury - At home, f		tory, office i	ouilding, etc.	or Town, S		er or Rural Route Number, City
determined (Specify) Single Family 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at and manner stated.						due to the caus	se(s) and manner	as stated.		
To the within 2 To the complet	Medical	29b. Signature and title of certifier	and manner stated.	mnadon and/of	mvesagation, li	29c. Licens		at the time, date		
			1~~			O.C.			April 19, 20	ed (Month, Day, Year) 1009
		30. Name and address of person who Donna M. Vincenti, MD				nn Street	, Baltimore, M	ID 21201		

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

LUNE

31. Date filed (Month, Day, Year)

09-03112

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

ona Francis W		State of	Maryland / Depa	rtment of	Health ar			200	9 34	
		1- For State Registrar	Cer	tificate of	Death			. No.		
Physicia edical Exami		1. Decedent's Name (First, Middle,Last) Fiona Frances					2. Date of Death Month April 18, 20	Day Year 09	3. Time of Death 0925 hrs	
		4a. Facility Name (if not institution, give str 13 Washington Street	reet and number)	4	b. City, Town, o Middletowr	r Location of Deat ใ	h	4c. County of Deat Frederick	h	
Funeral Director		5. Social Security Number 6. Sex 767–60–1870	7. Age (In yrs. la	ast birthday) Yrs.	If Under 1 Ye Months Da			(MM/DD/YYYY) 9. Bit 23, 2007 Co		
ń		Usual Residence of Decedent 10a. State 10b. County		Town or Location	200		Harch	25, 2047	10d. Inside City Limits	
and Show an	or	Maryland Frederick		Middleta					1 X Yes 2 No	
the Maryl 1 or 28a-1 iffed at 9	Director	10e. Street and Number 13 Washington St	treet		10f. Zip Code 21769)		g. Citizen of What Cou U.S.A.	intry?	
hours after death with the Maryland "natural", or items 23a or 28a-f show any Examiner must be notified at once.	Funeral	11. Marital Status 1 XNever Married 2 Married	Was Decedent Ever in U. Armed Forces?			ispanic Origin? (S in, Mexican, Puert	Specify Yes or No- o Rican, etc.)	14. Race - Amer White, etc.	ican Indian, Black,	
rs after de ural", or miner m	by	3 Widowed 4 Divorced If your 15. Decedent's Education (Specify only h	r Dates:		Yes 2XX N	o specify: ation (Give kind of	work done	Specify: What 16b. Kind of Business.	nite	
36 in 72 hou ian "nati lical Exa	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		ost of working lif	e. DO NOT use re		N/A		
d with	mo:	17. Father's Name (First, Middle, Last)		-		18.Mother's Nan	ne (First, Middle, M			
21215-0036 and be filed within 7 Mental Hygiene. marked other than cevent, the Medica	Be C	Christopher Al	lan Wood				cie Lyn B			
	То	19a. Informant's Name/Relationship (Type Mr. Sam Billotti	e, Print) III Grandfath	19b. Mailing 1 er 495	Address (Stre	eet and Number or Sie Ave.	Rural Route Numb	per, City or Town, State	e, Zip Code) '03	
Baltimore, MD permit. Pages 1 and 2 sho Department of Health and Important: If item 27 is injury or other traumat		20a. Method of Disposition 1 XXBurial 2 Cremation 3		Place of Disposi crematory or oth				20c. Location - City o	Town, State	
timent critant:		4 Donation 5 Other Specify:								
Bat permi Depar Impo	1	21. Scinature of Funeral Service I censee	√ MOO2	255 10	teeney a 06 East	ind Basfo Church S	ord PA Fu St., Fred	meral Home erick, MD	21701	
Physician /Medical	, , , , , , , , , , , , , , , , , , ,	23a. Part I. Enter the disease, or complica failure. List only one cause on each Immediate Cause (Final disease a. Gu		. Do not enter th	ne mode of dying	g, such as cardiac	or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and Death	
xaminer		or condition resulting in death)	e to (or as a consequence o							
	iner	Sequentially list conditions, if any, leading to immediate Due cause. Enter Underlying Cause	requentially list controllors, for any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause							
ecuted and - transit	Examiner	(Disease or injury that initiated events resulting in death) Last	e to (or as a consequence o	f):						
), be executed sician and urial - trans	dical		AMENDED							
Box 68760, e death certificate be execut the attending physician and ed for use as the burnal - tra	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preg Live birth	₂ Fet	tal death 3	Ectopic pregi	nancy	23d. Date of delive Month	ry Day Year	
Box e death c the atten ed for us	hysic	1 Voc 2 nd No 0 Hakasıya	Pregnant at time of de Unknown	5 Oth	ner (Specify)			0		
P.O. es that the	by	Part II. Other significant conditions co	ontributing to death but not re	esulting in the u	nderlying cause	given in Part I.		pacco use contribute to 2 No 3 Pro	o the cause of death? Obably 4 Unknown	
of Vital Records, P.C. ing Physician: The law requires that After this certificate has been signed to uneral director, page 2 should be deta	Completed			_			24a. Was a autops	y prior to	utopsy findings available completion of cause of	
Rec The la	Com	14					perform 1 V Yes 2		es 2 No	
Vital Rec ysician: The I his certificate I director, page	Be (25. Was case referred to medical examiner?	spital:			Other				
f Vi Physi er this	ပ	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injury	ER/Outpatient 28b. Time of tr		jury at Work?		Residence 6 Other	er: Scene	
sion of \\ .ttending Ph. death. ctor: After tl	ation:	1 Natural 5 Pending 2 Accident Investigation	FOUND: Apr 18, 2009	FOUND: 0909 hrs	1	Yes 2 V No	Subject shot			
Divis	28. Place of Injury - At home, farm, street, factory, office building, etc. 28. Location (Street and Number or Rural Route Number or Rural Route Number or Town, State) 3 Suicide 4 W Homicide 28. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 13 Washington Street, Middletown, MD 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
To the Hosy within 24 ho To the Fun										
T W F 3	Me	29b. Signature and title of certifier	nd manner stated.			nse number		29d. Date signed (M April 19, 2009	onth, Day, Year)	
		30. Name and address of person who com	<u> </u>		Popp Street	et, Baltimore,	MD 21201			
S	tate		32. Registrar's Signatu		renn suee	i, pailillole, l	- IVID 2 1201			

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Christopher Alan W	State of Maryland / Department of Certificate of Registrar		ene 2009 134
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last) Christopher Alan Wood	M	ate of Death onth Day Year oril 18, 2009 3. Time of Death 0925 hrs
	4a. Facility Name (if not institution, give street and number) 13 Washington Street	4b. City, Town, or Location of Death Middletown	4c. County of Death Frederick
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 590-72-0130 X M 2 F 34 Yrs	Months Days Hours Min.	Date of Birth (MM/DD/YYYY) 9. Birthplace (State or May 14, 1974 Foreign Arkansas
nd ihow any <u>ce.</u>	Usual Residence of Decedent 10a. State		10d. Inside City Limits
r death with the Maryland or items 23a or 28a-f show must be notified at once. Funeral Director	10e. Street and Number 13 Washington Street	10f. Zip Code 21769	10g. Citizen of What Country? U.S.A.
s afte	Armed Forces? 1 Yes 2 X No 3 X Widowed 4 Divorced Iff Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedenty 16a. Decedenty 16b. Decede	as Decedent of Hispanic Origin? (Specify es, specify Cuban, Mexican, Puerto Rican Yes 2X No specify: nt's Usual Occupation (Give kind of work of the control of the contro	n, etc.) White, etc. Specify: White
-0036 1 within 72 hour giene. The than "natu e Montal Exan completed		Accountant	Railroad
21215-0036 ould be filed within 7 d Mental Hygiene. s marked other than it event, the Mental TO Be Comple	Jerry E. Wood	Annette	Richardson
and 2 show tealth and tem 27 is traumatit	Mr. Jerry E. Wood, Father 4558	Oak Bay Drive West	Route Number, City or Town, State, Zip Code), , Jacksonville, FL 32277 e 20c. Location - City or Town, State
Baltimore, permit. Pages I at Department of He. Important: If ite	4 Donation 5 Other Specify:		24, 2009 Middletown, MD
	1/60		, Frederick, MD 21701
Physician /Medical xaminer	failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Intraoral Shotgun Wound Due to (or as a consequence of):		Between Onset and Death
nsit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): Due to (or as a consequence of):		
tO, e be executed ysician and burial - transit	d. UNPENDED AMENDED		
Division of Vital Records, P.O. Box 68760 the Ilospital or Attending Physician: The law requires that the death certificate hin 24 hours after death. The Functal Director: After this certificate has been signed by the attending physiophysicial in by the functal director, page 2 should be detached for use as the lifed in by the functal director, page 2 should be detached for use as the lical Certification: To Be Completed by Physician/Me	past 12 months?	etal death 3 Ectopic pregnancy ther (Specify)	23d. Date of delivery Month Day Year
P.O. res that the signed by 1 be detached by P.O.	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
Division of Vital Records, tal or Attending Physician: The law require as after death. "al Director: After this certificate has been signed in by the funeral director, page 2 should be ertification: To Be Completed			24a. Was an autopsy findings available prior to completion of cause of death? 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
Vital Rec hysician: The l this certificate l il director, page	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien	26.Place of Death (Check only of the 3 DOA Other Williams) Nursing Hot	
ion of Vitering Physics Physics I after the functal ation: Talental ation: Talental I ation: Talental	27. Manner of Death 1 Natural 5 Pending Prof Death 28a. Date of Injury Prof Death Prof Death Prof Death Prof Death Prof Death Deat		Describe how injury occurred ject shot self
Division (Hospital or Attendin, 24 hours after death. Funeral Director: All tells filled in by the fur all Certification	3 Suicide 6 Could not be determined (Specify) Single Family 28e. Place of Injury - At home, farm, stree (Specify) Single Family		Location (Street and Number or Rural Route Number, City or Town, State) Ashington Street, Middletown, MD
Dit To the Hospital of within 24 hours a To the Funeral IT completely filled	Check only one) 1 Certifying Physician: To the best of my knowledge, death occur one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.		
T × T ×	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) April 19, 2009
2		1 Penn Street, Baltimore, MD 2	1201
State Registrar	31. Date filed (Month, Day, Year) 32. Registrar's Signature	the state of the s	
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law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director /
completely filled in by the f

the Maryland

Baltimore, Maryland 21215-0036

Hma Suil MIS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GAS KENT AVE. SUITE ACY CUMBERLAND, MD 2KG HUMA SHAKIL, M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year)

State Registrar

State of Maryland / Department of Health and Mental Hygiene 2 0 0 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Day 23, 2009 6:15 P. M April Henry P. Ackerman, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1001 Western Run Road Hunt Valley Baltimore County If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 1 M 2 F 234-10-4868 Director Oct. 26, 1917 West Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sho Director 1 ☐Yes 2 No Hunt Valley Maryland Baltimore County 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? filed within 72 hours after death with Hygiene. 1001 Western Run Road 21030 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? T. Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 res, Give Year or Dates: W.W.II 1 ☐Yes 2 ☐ No Specify: ģ Specify: White 3X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) United States Elementary/Secondary (0-12) College (1-4or 5+) 12 04 2 should be filed wi and Mental Hygier Is marked other th Lieutenant Colonel Army 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry P. Ackerman, Sr. Lempi H. Huhtala 19a. Informant's Name/Relationship (Type. Print) (Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is r Patricia A. Phataminviphas 1001 Western Run Road Hunt Valley, MD. 21030 April 28 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Important: If it any injury or c 1 Burial 2 Cremation 3 Removal from State Bosley U.Meth.Ch.Cem. 4 ☐ Donation 5 ☐ Other (Specify) 2009 Sparks, Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facility eaceful Alternatives Funeral&Cremation Ctr.,P.A. 2325 York Road Timonium, Maryland 21093 e, or complications that caused the death. Do not enter the mode of dyin, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part 1. Enter the disease shock, or heart failure. Immediate Cause (Fin disease or condition Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) sician and burial-tran Due to (or as a consequence of) Box 68760, physician requires that the death certificate be Physician/Medical the as nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No ed by the detached f o 9 Unknown 9 🗌 Unknown 4 signed be det 23e. Did tobacco use contribute to the cause of death? significant conditions contributing to peath but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 2 100 1 ☐ Yes 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Physician: The law autopsy performed? Yes 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ N Other: 4 \square Nursing Home 5 Besidence 6 ☐ Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manper of Death 1 Minatural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After 1 28c. Injury at Work? Hospital or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 09 27 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rd 2221 amore 1 monium 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

APR 28

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** John Lawrence Adams 135 AM 27 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore FRANKLIN SQUARE HOSPITAL CENTER Rosedale If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Hours 1 X M 2 □ F 216-16-5060 84 Director June 13,1924 Baltimore, MD Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show injury or other traumatic event, the Medical Examiner must be notified at Baltimore Director MD Parkville 1 ☐ Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō 3405 Glenside Drive 21234 U.S.A. "natural", or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XX Yes 2 □ No If Yes, Give Year or Dates: WWIII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status illed within 72 hours after 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White ک و 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Cas Station marked other than Elementary/Secondary (0-12) College (1-4or 5+) Business Owner Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and 2 should be and Mental Howard Adams Emma Palmer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any injury or other trau 3405 Glenside Drive, Parkville, MD 21234 Pamela Adams/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)

Evans Funeral Chapel 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 04/30/09 Forest Hill, MD 4 ☐ Donation 5 ☐ Other (Specify) Air 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services Parkville . Signature of Funeral Service Licenses 8800 Harford Rd. Parkville, MD 21234 Approximate Interval Between Onset and Death th. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ock, or hear thilling. List only one cause on each line. Imm ciate Cause (Final dis 4se or condition resulting in death) Physician Sepsis

Due to (ras a consequence of): /Medical Examiner adenocarcinoma metastatic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physician and the burial-transit Due to (or as a consequence of) P.O. Box 68760 The law requires that the death certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4 Pregnant at time of death 5 ☐ Other (specify) 1 □Yes 2 □No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 ☐ Yes 2 1No 1 ☐ Yes 2 ☐ No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 To the Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation hours after death. 2 Accident within 24 hours after death To the Funeral Director: Location (Street and Number or Rural Route Number, City or Town, State) Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 4.27.09 DR Juan 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, HDZ1231 59 vane drive 900 RIVEra 31. Date filed (Month, Day, Year) Registrar's Signature State APR 28 2009 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? 1 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 6:31 PM APRIL DAMS 2009 YIARI /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BAYNEW MEDICAL CENTER BALTIMORE JOHNS HOPKINS 7. Age (In yrs. last birthday) If Under 1 Year | If Under 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1□ M 2 🗙 🛣 Months Hours Director 216.42.9577 SEP. 15, 1944 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 □Yes 2 No Director ANNE ARUNDEL GLEN BURNIE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7978 CROWNSWAY USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes **XX**No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 □ Yes 2\X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√√No Specify ģ Specify WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any injury or other traumatic event, Its Maonce. Elementary/Secondary (0-12) College (1-4or 5+) 12 PACKER TOOL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ HARRY S. STANDIFORD SR. LOUISE A. CHANEY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOHN M. ADAMS HUSBAND 7978 CROWNSWAY, GLEN BURNIE, MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2√ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) BAYVIEW CREMATORY INC. APR. 21, 2009 BALTIMORE, MD o Funeral Service Licensee 22 Name and Address of Facility FINK FUNERAL HOME, P.A. CRECORY FINE 426 CRAIN HWY. S., GLEN BURNIE, MD 21061 Enter the dire se, or implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failur. List in vione cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Fin I disease or Indition resulting in Sth) **Physician** PANCREATITIS SEVERE DAYS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) ospital or Attending Physician: The law requires that the death certificate be executed hours after death.

In ineral Director: After this certificate has home shown changes. burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending pl for use as t IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💓 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an cate has bage 2 s autopsy performe 1 □ Yes 2 XNo funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2⊠No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 ☐ Accident 1 ☐ Yes 2 No filled in by the 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a Hospital DECertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number MEDICAL DOCTOR 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 JUSTIN EASTERN BALTIMORE AVENUE

State

Registrar

31. Date filed (Month, Day, Year)

APR 28

kegistrar's Signatur

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . ^{Day}2009 April 25, **Physician** Ash 2:30 a M Yolanda /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bel Air Harford 73 Crystal Court If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Min. 1923 Months. Hours Mary Tand 220-14-3711 85 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatlh and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Medical Examinar must be notified at Director 1 ☐ Yes 2 ☐ No Harford MD Abingdon 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21009 U.S.A. 20 Box Hill South Parkway Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐**X**No Specify: Specify: White \$ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own home 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Daniel Marshall Maria Busciacco ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia A. Walker-daughter 73 Crystal Ct., Bel Air, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State New Cathedral 4/29/09 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fuperal Service Licensee William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Pulmon Ary Edem A
Due to (or as a consequence of): weeks disease or condition resulting in death) /Medical Examiner Congestive Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner the death certificate be executed CATOLOMYOPAthy and burial-trar resulting in death) Last Due to (or as a consequence physician a Physician/Medical attending properties for use as as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Ö the 9 Unknown þ σ. signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 3 Hypertension, Renal Disease, myocardia 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Infarction, Antherosclerosis, Chronic Obstructio 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 certificate has autopsy performed Pulmonary 2 No DISCIPLE 1 ☐Yes 2 ☑No 1 ☐ Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 6 Other (Specify) Other: 4 Nursing Home 5 Residence 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) After thi 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending he Funeral Director: Af 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital 29a, Certifier 1 🗜 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D39763 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2012 Tollante Rd, Ste 102, Bel Air, Marpland 21015 , m.D. TAnnenbavm

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

Registrar's Signature

32.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 9 Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Day **Physician** '00 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner dauathers achdiess M Under 24 Hrs. Date of Birth (Month, Day, If Under 1 Year **Funeral** Hours Months Days 0 Usual Residence of Decedent Director death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 7 Is marked other than "natural" or items 23a or 28a-f sho traumatic event, Ire Medical Examinating that be notified at 1 Yes 2 No Director 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 □Yes 2 □ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 Yes No ۵ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry econdary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ith and Mental h Be 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a item 27 other to 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Methed of Disposition jo Department of Important: If it any injury or o 1 Burial 2 □ Cremation 4 ☐ Donation 5 ☐ Other (Specify) 2829 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-tra Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical attending ph IF FEMALE f yes, outcome of pregnancy □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 r Month Pregnant at time of death 5 Other (specify) s been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 2 □ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has , page 2 s autopsy certificate 1 □Yes funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 \sum Nursing Home 1 ☐ Yes 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence Certification: To her (Specify After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A 2 ☐ Accident investigation the 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certif 29d. Datersigned (Mointh, Day, Year) 30. Name and address death (Item 23a) (Type, Print) FALS RD, SUITE 200 LUTHERVILL 31. Date filed (Month, Day, Year) 32 State ADD 90 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland, Department of Health and Mental Hygiene 31, 19 1 - State Registrar Reg. No. U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April **Physician** 25 200⁹ 6:32 РМ James Keith Brooks /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Baltimore Towson 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1¥ M 2∏ F Months Days Hours Min 113-12-5269 83 **Director** North Carolina Nov.11,1925 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at 10d. Inside City Limits Director Maryland Baltimore County 1 ☐ Yes 21 No Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 148 Springside Drive 21093 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Armed Forces:
1 Styles 2524-15/1943If Yes, Give 4/15/1944Year or Dates: 4/11/1946
16: 1 Never Married 2 Married 1 ☐ Yes 2 1 No ģ Specify Specify: White 3₺ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Captain Merchant Marine 7 is marked other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Holshouser James Franklin Brooks Pearl-ဂ္ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health Important: If Item 27 i any injury or other tra once. 27 Tracey L. Sazaklis (Daughter) 9417 Gunview Road Baltimore, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State April 2009 23, Evans Funeral Chapel Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Peaceful Alternatives Funeral&Cremation Ctr., P.A
2325 York Road Timonium, Maryland 21093 re of Funeral Service Licenses the disease eart failure Li r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Selsis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Ineymonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Pspiratou law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) $\mathcal{A}\mathcal{A}\mathcal{A}$ \mathcal{A} , $\mathcal{M}\mathcal{E}/\mathcal{C}\mathcal{E}\mathcal{P}$ Records, P.O. Box 68760, Incarcaded heria Physician/Medical Uhsh chen IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 disease Vascula 3 Probably 4 Unknown Completed 1 ☐ Yes 2 ☐ No hob all alex 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Division of Vital 1 □ Yes 2 No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 Pending investigation 1 Natural within 24 hours after death.

To the Funeral Director: All completely filled in by the fu death. 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 4(26/09. MID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (It ms To putter 32. Registrar 31. Date files State Registrar

OK IXINS

Amend #30 State of Maryland #Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 23 LENA Α. BETHUNE APRIL 2009 16:18 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner JOHN HOPKINS BAYVIEW BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 M 2 X Director 95 219-22-6462 06-07-1913 NC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 and 2 should be filed within 72 hours after death with the Marylan Heath and Mental Hygene. set 27 is marked other than "natural", or items 23a or 28a-f show wither traunatic event, I'm Medical Express. 1XYes 2 No Director BALTIMORE MD TURNER STATION 10g. Citizen of What Country? 10e Street and Number 10f, Zip Code 126 WILLIAM WADE AVENUE 21222 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify þ 3 X Widowed 4 □ Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **CLERK** CGR MEDICAL CORPORATION 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CARRIE MCARTHUR JOHN ADDISON ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DEBORAH BETHUNE MICKEY/DAUGHTER 8429 COVE RD. BALTIMORE, MARYLAND 21222 permit. Pages 1 and. Department of Health Important: If item 27 any injury or other tr Baltimore, 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) ARBUTUS MEMORIAL PK. 4-29-2009 BALTIMORE, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC 1701 LAURENS ST., BALTO., MARYLAND 21217 01 23a. ParM. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caus, on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner parlendion Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (mas a consequence of) Examine burial-transit and Due to (or as a consequence of). P.O. Box 68760 Physician/Medical the attending pl IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe certificate 2 No 1 ☐ Yes 2 1 No 1 ☐ Yes 25. Was case referred edical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Peath 28b. Time of 28d. Describe how injury occurred After t Certification: 28c. Injury at Work? 5 Pending investigation or Attending 1 Mural Injury 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director; A 2 Accident filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Hospital 1 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cert 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Theodore Alexander Stephens, MD 1005 North point Blvd. Baltimore, MD 21224 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 28 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2009 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** RAD2 2:05PM CARE' 2009 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NIA Himore If Under 24 Hrs. 8. Date of Birth A (Month, Day, 5. Social Security Number 6. Sex Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year) Min. Months Days 1 1 M 2 □ F 95 Hours Alahama 406-03-1666 Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 28a-f show Funeral Director 1 Yes 2 No Honoro 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number þ 2121 traumatic event, the Medical Examiner must Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 ō 1 ☐ Yes 2 ☐ MO Specify 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Communi 12 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last Be and Mental 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 19a. Informant's Name/Relationship (Type. <u>.0</u> lene Dalto other t Department of Heal
Important: If Item 2
any injury or other Baltimore. 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 of 1 □ Burial 2 □ Cremation 3 Removal from State Zion Cempter 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses HOWELL FUNELAL HOW HEIGHTS 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 36951S **Physician** /Medical Due to (or as a consequence of): Examiner SAVERE ANAEM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed CARDIOMYOPATH Due to (or as a consequence of) P.O. Box 68760 (HM2 DNIC IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ۾ 2 No 3 ☐ Probably 4 🛱 Unknown Completed UKER 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No DECURITUS 24a. Was an autopsy performed? Yes 2 No MALNUTRITION 1 ☐ Yes Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA in by the funeral dir Certification: To this 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after deatl To the Funeral Director: 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical completely and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) m.D D61439

State

2600

MIBERTY HEIGHTLS

MENUE

BALTIMORE MY 21215

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Y 6mist

31. Date filed (Month, Day, Year)

m. 0

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2009 Physician 4:50 15, April Lester Trueman Burn, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3 Chalkstone Court Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, **Funeral** Days Hours Year) 1 X M 2 □ F 66 1942 Washington, DC Director 218-38-6915 April 17 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 28a-f show 1 TyYes 2 □ No Director Silver Spring Maryland Montgomery 10f Zin Code 10g. Citizen of What Country? 10e. Street and Number ral", or items 23a or Examiner must be r 20904 U.S.A. Funeral 3 Chalkstone Court 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 ☐ No If Yes, Give Vietnam 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
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Department of
Important: If it
any Injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4-23-09 Parklawn Mem. Park Rockville, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Colonial Funeral Home of Leesburg 201 Edwards Ferry Rd. NE Leesburg, VA 20176 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CORTICAL LOYEGA /Medical Examiner NSWOU wastw9 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine requires that the death certificate be executed Box 68760, 27 Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1X Yes 2 □ No 2 400 1 ☐ Yes Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∏ Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 XNatural 5 Pending investigation s after dea. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D006H0 (Item 23a) (Type, Print) who completed cause of d 30. Name and address of person lone Cherry 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Baltimore, Maryland 21215-0036

P.0.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 2009 Patricia J. Bloom (If not institution, give street and number) or Location of Death 4c. County of Death Ka lare If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 20, 1936 Birthplace (State or Foreign Country) (In yrs. last birthday) Days 1□ M 2 🗗 F Months Hours 212-42-9321 England 72 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Baltimore 1 ☐ Yes 2 ☑ No Essex 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 202 Cove Road 21221 England Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2★ If Yes, Give Year or Dates: 2**X** No 1 ☐ Never Married 2 ☐ Married 1 ∐Yes 2 XXNo Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unknown Maude Lake 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George R. Bloom /husband 202 Cove Road Baltimore MD 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory 4-28-09 4 ☐ Donation 5 ☐ Other (Specify) Baltimore MD 21. Signatur Funeral Service Licensee 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Dus to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year Month 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy 2 **X**No 2 No 1 □Yes 1 Yes 26. Place of Death (Check only one)

/Medical Examiner The law requires that the death certificate be executed burial-trar physiciar the use as ō signed by the a certificate

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Department of Heal Important: If item 2 any injury or other once.

Physician

Pages 1 and 2 should be f

Baltimore, Maryland 21215-0036

in the past 12 months? 1 ☐ Yes 217 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Was e referred to medical examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 14 Natural 1 ☐ Yes 2 🗆 No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier

29d. Date signed (Month, Day, Year)

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Medical

29b. Signature and title of certifie

doi filed (Month, Day, Year) 000 Frank

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Delmar Leroy Bau		1- For State	State	of Maryla		-	ment of		and	Menta	al Hygi		·	200	10	1342
Physiciar	1/	Registrar 1. Decedent's Name (First,										Reg. No. 2 0 3 Time of Death 3. Time of Death				3. Time of Death
Medical Examin			ublit							Month Day Year 1348 hrs				1348 hrs		
	H	4a. Facility Name (if not ins 15029 Jarrettsville	stitution, give street and number)					4b. City, Town, or Location of Death Monkton			Death			4c. County of Death Baltimore County		tv
Funeral	7	5. Social Security Number	6. S e	×	7. Age (In	yrs. last	birthday)	If Under		If Under	24Hrs. 8.	8. Date of Birth (N		I/DD/YYYY) 9). Birthp	,
Director	1	219-42-5543	1 X	M 2_F		6	4 Yrs.	Months	Days	Hours	Min.	A119.	5.	1944 F	oreign Coun	try) Maryland
		Usual Residence of Decede	nt			_						21081	<u> </u>			
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Maryland 28a-f show	흱	MD 10e. Street and Number	Baltin	nore			Monk	ton 10f. Zip Co	nde			T	10a Cit	tizen of What		
vith the Maryland s 23a or 28a-f shov enotified at once	Director	15029 Jarrettsville Pike											rog. Cii	USA		y :
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2 hour	Completed	15. Decedent's Education Elementary/Secondary (0)		College (1		ea) 16	6a. Decedent during mo	s Usual Oc st of workin				done	16b.	Kind of Busin	ess/Ind	lustry
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AD 2 shou and N and N matic											nber or Rural Route Number, City or Town, State, Zip Code) d Reisterstown, MD 21136					
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MOFe, Pages 1 at tent of He unt: If ite		1 Burial 2 X Crem 4 Donation 5 Oth		Removal fro	m State	At1a	matory or oth antic	Cremat	tory	, '	April 2009			Glen Bu	ırni	e. MD
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once	t	21. Signature of Funeral Se	icens	see			22. N	ame and Ac	Idress o	f Facility				ney Val		
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ox (sath ce attend for use		1 Yes 2 No 9	Unknown	4 Pregna	ant at time	of death	5 Oth	er (Specify)				Î			
D. B. It the de by the ached for	5	Part II. Other significant co	nditions			not resu	Iting in the u	nderlying ca	use giv	en in Part I	l.	23e. Did to	obacco	use contribut	e to the	e cause of death?
S tha	6											1 Ye	s 2	/ No 3 □	Probab	oly 4 Unknown
Division of Vital Records, tal or Attending Physician: The law requirer and part death. 11 Director: After this certificate has been signed in by the funeral director, page 2 should be relificated by the funeral director, page 2 should be required.							_				- 1	24a. Was				osy findings available
Reco The law cate has										performed? 1 ✓ Yes 2 No 1 ✓ Yes 2 No						
Vital Recognition of the continuation of the c		25. Was case referred to me examiner?						26.	Place o	f Death (Cl	heck only				, , , ,	
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Hosp 24 hor Funce etely fi		29a. Certifier 1 Certifyii	g Physicia	n: To the best				ed at the tin	ne, date	and place	e, and due	to the caus	se(s) ar	nd manner as	stated.	
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the				On the basis o and manner st		ion and/	or investigati				rred at the	time, date				
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;	1	 Namé and address of pe Russell Alexander 		completed cause Assistant M			•	Penn Str	eet, B	altimore	e, M D 2	1201				
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Division or Vital Records, P.O. Box 68760, To the Hospital

Certification: within 24 hours are:
To the Funeral Director: Aff 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES COI APRIL 22, 2009. Milana

LUCIANA ALMEIDA 31. Date filed (Month, Day, Year) State

30015. HANOUER ST 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

BALTIMORE, MD

State Registrar Madison

of death (Item 23a) (Type, Print)

Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 24, Ann Μ. Bowman April 2009 2:30 p.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Co. North Arundel Health & Rehabilitation Glen Burnie If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months Days Hours Min 1 □ M 2 🕅 F Director 89 Jan 12, 1920 219-10-1245 Virginia Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 2 should be filed within 72 hours after death with the Maryla I and Mental Hygiene.

Is marked other than "natural", or items 23a or 28a-f shov raumatic event, the Madical Eventing must be notified at 1 ☐ Yes 2X No Directo Anne Arundel Co. Glen Burnie Marvland| 10e. Street and Number 10g. Citizen of What Country? 313 Hospital Drive 21061 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black White etc. 1 Never Married 2 Married 1 ∐Yes 2X No Baltimore, Maryland 21215-0036 2 If Yes, Give Year or Dates: 1 ☐ Yes 2 XNo Specify. White Specify 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5 yrs. Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Donald Terry Florence Branham ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 to Department of Health an Important; If Item 27 Is any injury or other trau Mr. Donald Bowman / Son 569 Beech Drive Lusby, Maryland 20657 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Glen Haven Mem. Park 4/30/2009 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, Maryland 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service Licensee M01357 Services PA; 1 2nd Ave SW, Glen Burnie, MD 21061 Vancer 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, ox heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 178 to (or a a consequence of) /Medical **Examiner** Sequentially list conditions Examine it any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) law requires that the death certificate be executed and Due to (or as a consequence of): burial-Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) P.0. 1 ☐ Yes 2 ☑ No the 9 Unknown þ been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ğ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has be rector, page 2 sl 24a. Was an The perform 1 ☐ Yes 2 XVIVo 1 ☐ Yes 2 No or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No this 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After th funeral 28a. Date of Injury (Month, Day, Year) 27 Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 🗆 No 2 TAccident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

State Registrar 29d. Date signed (Month, Day, Year)

and manner stated.

208

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** April 22, 2009 10:49P M IRGINI /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Co. Middle River 2116 Vailthorn Road If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth (Month, Day, Year) May 7, 1927 **Funeral** 6. Sex 7. Age (In vrs. last birthday) Days Months Hours 1 □ M 2 🖾 F Virginia Yrs Director 217-20-9390 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. "Inportant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event; It is Maryland Evantine in ust be notified at appear. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Middle River Maryland Baltimore 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21220 United States 2116 Vailthorn Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 □Yes 2X No Specify: Specify: 3₺ Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 8 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rosie Mae Gross Albert Sydney Falls ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melody A. Burton (Daughter) 2116 Vailthorn Road Middle River, Maryland 21220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/25/2009 Oak Lawn Cemetery Baltimore, Maryland ☐ Donation 5 ☐ Other (Specify) ure of Funeral Service License 21. Sign ²²Duda-Ruck Funeral Home of Dundalk, Inc. Dundalk, Maryland Ave. Approximate Interval Between Onset and Death Part to the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** evener /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1∐Yes 2☑No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

State Registrar

29b. Signature and title of certifier,

30. Name and address of person

31. Date filed (Month, Day, Year) APR 28 2009

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Sanature

JOHL

29c. License number

H35593

124 Macetve, Bath.

29d. Date signed (Month, Dav. Year)

State of Maryland / Department of Health and Mental Hygiene () () Q

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			For State Registrar		Oldio 0	, mary marr	Cei	tificate of	Death	montal 17	Reg. No.	.000	10460	
	Dharisi		1. Decedent's Name (F	First, Middle, Las	st)					2. Date of De	ath Day	Year	3. Time of Death	
	Physici /Medic		Jo	ohn	Joseph	Ва	rberia			April		2009	7:10 A M	
The sales	Examin	er	4a. Facility Name (If no			mber)		-	r Location of Deat	h	1	County of Death		
4			7825 St. 1				44:41-4	Dui	ndalk Tif Under 24 Hrs	O Data of Bi		altimore		
	Funeral Director		5. Social Security Numb	99 1	ex Mr 2□ F	7. Age (In yrs. I	Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da Nov • 9	, 1923	B Pen	olace (State or Foreign ntry) nsylvania	
980	and	Funeral Director	Usual Residence of De 10a. State 10	cedent b. County		10c. City	, Town or Lo	cation				1	Od. Inside City Limits	
	Maryli f sho		Maryland	Ba1	timore				Dundall	K			1 □Yes 2 🛣 No	
	th the Marylar or 28a-f show		10e. Street and Numbe					10f. Zip Code			10g. Citiz	en of What Coul	ntry?	
	rs after death with the Maryle ", or items 23a or 28a-f sho	O IE	7825 St.	Bridge	t Lane		21222					United States		
		ner	11. Marital Status		12. Was Dece Armed Fo	edent Ever in U.S	3. 13. V	Was Decedent of H	Hispanic Origin? (S an, Mexican, Puer	Specify Yes or No		4. Race - Americ Black, White,	can Indian,	
	72 hours after "natural", or ite ofical Everyies	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:					I⊡Yes 2⊡KNo	Specify:		Specify: White			
5-0	72 hour "natural"	Completed	15. (Specify o	. Decedent's Econly highest gra	lucation de completed)		(Give	lent's Usual Occup kind of work done	during most of wo.	rking	16b. Kin	nd of Business/In	dustry	
121	/ithin	mp	Elementary/Seconda	ry (0-12)	College (1	-4or 5+)		OO NOT use retire	d)					
2	lled w lygie ther t	To Be Co	12 Yea:				Pai	nter	18 Mother's Na	me (First, Middle		nip Yard		
anc				h Barbe						y Rodano		ourname)		
Z			19a. Informant's Name				19h Mailin	a Address (Street	and Number or R	<u> </u>		Town State Zin	Code)	
Z			Carol Po		(Daught	er)		_					and 21221	
ē,			20a. Wethod of Disposi			20b. P	lace of Dispo	sition (Name of natory or other place	na)	Date	20c. Loc	cation - City or To	own, State	
9			f Burial 2 □ C 4 □ Dopation 5 €			Siale I			Cem. 4/2	4/2009	Bal	ltimore.	Maryland	
Baltimore, Maryland 21215-0036			21. Signature of Funera				22 D	Name and Addre	ess of Facility Funeral	Home of	Dunc	dalk. In	ic.	
			23a. Part 1. Enter the	lisease, or com	olications that o	aused the death			Ave. Du			land Zi	222 Approximate	
	Physician /Medical Examiner		shock, or heart fa Immediate Cause (Final	ailure. List only	one cause on e	ach line.	2 4	Dero.			_		Interval Between Onset and Death	
			disease or condition resulting in death)	-	a. Due to	(or as a consequ	ence of):	KIEF	1 11:	SEASE				
					AT	RIAI	FI	BRIL	A TIM	24				
		Je.	Communitative that an until form											
a A	and rransi	Examiner	Cause (Disease or inju that initiated events	iry	c. AT	12/AL		LARGE	MEN					
687605	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	<u> </u>	resulting in death) Last		Due to	or as a consequ		T10X						
87		Physician/Medical		•	d	ALN	4///	1104						
	ding p		IF FEMALE:		23c If yes out	come of pregna	ncv					Od Data at dath		
Box	eath ce attendii for use		23b. Was decedent pre in the past 12 mor	nths?	1 Live	1 ☐ Live birth 2 ☐ Fetal death 3 ☐			Ectopic pregnancy Other (specify)			3d. Date of deliv Month	ery Day Year	
0	that the de ned by the detached	ysic	1 □ Yes 2 □ No 9 □ Unknown	0	9 Unkr									
σ,	w requires that been signed by should be deta	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacc									co use contribute to the cause of death?		
rds		ğ D	1 Yes							Yes 2□	2 No 3 Probably 4 Unknown			
O O	law re as bee 2 sho	plet								24a. Was		24b. Were auto	ppsy findings available	
æ	sician: The law certificate has rector, page 2 s	Completed								auto perfo 1 □ Yes	prmed? 2 10 No	death?	ompletion of cause of	
ita	slan: ertifica ctor, p	BeC	25. Was case referred examiner?	to medical					26. Place of De	ath (Check only)		12100		
Y	Physic this ce al dire		1□Yes 2☑No			Inpatient 2 🗆	ER/Outpatier	t 3 □ DOA Oth	ner: 4 🗆 Nursing H	Home 5 Res	idence 6	□Other (Speci	fy)	
D C	ding Ph h. After th funeral	 6	27. Manner of Death 1 Natural 5	5 ☐ Pending	28a. Date (Mon	of Injury th, Day, Year)	28b. Time of Injury	Wor		28d. Describe	how injury	occurred		
Division of Vital Records,	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certified completely filled in by the funeral director, for	Certification: To	2 Accident	investigation Could not be		M 1 □Yes 2 □No				205 1 225 20				
Ν		Ħ	4 ☐ Homicide	determined	buildi	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specity)					28f. Location (Street and Number or Rural Route Number, City or Town, State)			
		2	29a, Certifier 1	CertifyIng Ph	ysician: To the	best of my kno	wledge, death	n occurred at the t	ime, date and plac	e, and due to the	cause(s)	and manner as:	stated.	
		Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
	To th withir To th comp		29b. Signature and title	of certifier				29c. Licens	se number		29d. Date	signed (Month,	Day, Year)	
	. \		> San	indo	11/11	ello,	MI	100	27188		4.	-23-	09	
	6x1		30. Name and address	of person who	completed caus	se of death (item	23a) (Type,	Print)	10	Ν.	1 . 1	R MI)	0.	
	_		Sunna	ule	wel	0 21	yar	ecil. 1	1 acc	Dunc	dal	(C 141)	2/222	
	Sta Registr		31. Date filed (Month, L	vay, Year)	32/ F	egistrar's Signa	l And	apple						
	negisti	al	AP	7 % 0 60	UJ JAKA	for po	4.4							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Jonth Ye ar :10^M Louise A. Bailey 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Union Memorial Hospital If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 □ M 2 🖫 F 86 **Director** 228-34-3441 Aug 6. 1922 Virginia Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Health and Mental Hygiene. First ST is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits iral", or items 23a or 28a-f show Director 1 □Yes 2 No Baltimore Baltimore Md. 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21207 6825 Campfield Rd 10F USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ White 3 ₩ Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Church Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 27 is marked o traumatic eve Charles Bernard Anderton, Sr. Mary Lillian Robins 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 60 Arlene Dr. Hanover, Pa. 17331 Mrs. Robin G. Crawford/ Daughter If item 27 or other t 3altimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) injury o 4-29-09 Dulaney Valley Mem. Timonium, Md. 21. Signature of Funeral Service Lice 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. pplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, y one cause on each line. 23a. Part 1. En er the disease, or o shock, or heart failure. List or Approximate Interval Between Onset and Death Immediate Cause (Final Physician sot obstructive disease or condition resulting in death) /Medical **Examiner** Broast Can Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be execute Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No □Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be

P.O.

Director: within 24 hours a

> State Registrar

DHMH 17 Rev 1/2001

completely

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

201 & University N 1.0 Registrar's Signatu RAHMAN

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

ABD EL

determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene 🕦 🖺 🔍 1 - For State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2009 2 Day H AMonth . **Physician** 11: 1574 M ELIZABETH MINNIE BOWDOIN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 18mm ne Anne (=)-en Baltimore Washington Med Ctr If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day,)9/23/ 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) Months Days Hours 91 220-20-6772 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 MNo Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Drive 7514 Steens Hill 21060 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 14. Race - American Indian. 1 Never Married 2 Married 1 ☐Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Yes 2 🗹 No þ 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Carr Lowery Elementary/Secondary (0-12) College (1-4or 5+) Glass Company 12 Carton Assembler 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harry William Schisler Edith Jacobs 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7514 Steens Hill Drive, Glen Burnie, MD 21060 Barry Bowdoin / Son 20a. Method of Disposition Entombment 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 4 □ Donation 5 □ Other (Specify) 04/23/09 | Baltimore, MD Cedar Hill Cem 21. Signature of Feral Service Licensee 22. Name and Address of Facility G.J.Gonce Funeral Home, 169 Riviera Drive, Pasadena, MD 21122 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final nehmoni disease or condition resulting in death) Due to (or as a consequence of): Heart Failure 7001 if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Day in the past 12 months? Month Year 4 Pregnant at time of death 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 1 Tes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 □ Yes 2 🖸 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 27. Manner of Death Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier **Terrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one)

Examiner Records, P.O. Box 687 of Vital the Hospital or Attending Physician: Division ithin 24 hours after death.

the Funeral Director: A

mpletely filled in by the fu

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at

12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "n

permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is a

Physician

/Medical

attending physician and for use as the burial-transit

the

signed by

director, page 2 should

has

this certificate

Maryland 21215-0036

3altimore,

State Registrar

29b. Signature and title of certified

29c. License numbe

29d. Date signed (Month, Day, Year)

30. Name and add ess of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. Ne. Date of Death
 Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Physician 9:15 Josephine 04 22 2,069 /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Washington Medical Ctr. Anne Arunde Glen Burnie If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03/19/1924 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🗹 F 85 216-20-6380 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 1 ☐ Yes 2 PNo Director Pasadena MD Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number a or U.S.A. 8468 Church Road 21122 "natural", or items 23a edical Examiner must Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑No Specify. þ 3 ₩Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within hand Mental Hygiene.
7 Is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) 12 Florist Florist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Seifert ဥ Joseph Fabizak 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 Is n any injury or other traun 8468 Church Road, Pasadena, MD 21122 Christopher Byrne Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 MCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 104/27/09 Baltimore, MD 21. Signature of Emeral Service Licensee 22. Name and Address of Facility G.J.Gonce Funeral Home, 169 Riviera Drive, Pasadena, MD 21122 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician day Cerebrouseway /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine sician and burial-transit be executed Due to (or as a consequence of) Box 68760. physician Physician/Medical as the attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) ned by the a 9 I Inknown 9 ☐ Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Stage renal disease 2 No 3 Probably 4 Unknown cate has been signated by page 2 should by 1 Tes Completed Disease 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No Artery 24a. Was an autopsy certificate Diabetes Melitus 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Naturai 1 ☐ Yes 2 ☐ No To the Hospital or Attendii within 24 hours after death.
To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

P.O.

Division or Vital Records,

State Registrar

29a. Certifier

(Check only one)

Medical

and manner stated. 29b. Signature and title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c, License number 29d. Date signed (Month, Day, Year)

DVGCCC MNCO

2007 0068123

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital Drive Glen Burnie, MD 21061 Vovacco LotigzoH smu

LCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

31. Date filed (Month, Day, Year) APR 28 2009

			Fau	Pleas	se Type or State o					. Ensure A	-		_	
			for State Registrar					ertificate				Reg. No.	0000	131,33
			1. Decedent's Nam	e (First, Middle	Last)						2. Date of D		y Year	3. Time of Death
	Physic /Medi		Benjami	n Back	over III						April	10,	2009	1:59 PM M
-	Exami	ner	i i	, and a second	give street and nu	,		4b. City, Town, or Location of Death					County of Deatl	
			5. Social Security N		11 Road		s. last birthday	1.7		ge City	8. Date of B	irth		George's
	Funeral Director		unknown Usual Residence o		6. Sex 1	51	_	Months	Days	Hours Min.	May 1	ay, Year)		nplace (State or Foreign untry) of Columbia
	yland now		10a. State	10b. County		10c. (City, Town or L	ocation.						10d. Inside City Limits
	a-fsl	ctor	MD			C	ottage	City						1 ⊠Yes 2 □ No
	h with the 23a or 28 st be no	al Director	10e. Street and Nur 4142 Bur		L1 Road			10f. Zip	Code 207	722		_	izen of What Co	untry?
980	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exporter traumatic event, the Medical Exporter.	by Funeral	11. Marital Status 1 ☑ Never Marr 3 ☐ Widowed	_	12. Was Dece Armed Fo 1Yes If Yes, Gi Year or D	rces? 2 No veA	U.S. 13.	. Was Deced If Yes, spec		dispanic Origin? (San, Mexican, Puer	Specify Yes or N to Rican, etc.)	0-	14. Race - Amer Black, White Specify: Wh	
5-0	72 hc	etec	(Spec	15. Decedent's	s Education t grade completed)		i (Give	edent's Usua e kind of won	k done	during most of wo	rking	16b. Ki	ind of Business/I	ndustry
Maryland 21215-0036	12 should be filed within: h and Mental Hygiene. 7 is marked other than " traumatic event, Inc. Nex	Completed by	Elementary/Second 10		College (1	-4or 5+)		DO NOT us Equipme		Refiller		1	e Protec	ction
and	be fill ntal H sd oth even	æ	17. Father's Name		_{ast)} ver. Jr.					18. Mother's Na		e, Maiden	Surname)	
7	hould nd Me mark matic	မ	19a. Informant's N				10h Mail	ing Addross	(Stroot	Genny		har City a	r Town State 7	in Codo)
	1 and 2 s Health ar tem 27 is	ļ,		ackover				alling Address (Street and Number or Rura 113 Decatur Street						
altimore,	e = 5		20a. Method of Dis 1 ☐ Burial 2 4 ☐ Donation	□ Cremation :	3 □Removal from ecify) insta	State	comptony promotony or other place)			Date	20c. Lo	ocation - City or I	Fown, State	
4 Donation 5 Mother (Specify) instate 21. Signature of Funeral Service Licensee Ronald S. Wade, Director							22. Name and		ss of Facility St Street		-	Board 6 MD 212		
	Physician /Medical	resulting in death) a. Due to (or as a consequence of):											Approximate Interval Between	
	cuted ansit	Examiner	Sequentially list co if any, leading to im- cause. Enter Unde Cause (Disease or that initiated events	nditions, nmediate orlying injury	b. Due to	or as a conse	equence of):							
68760,	ficate be executed physician and s the burial-transit		resulting in death)	Last	Due to	or as a conse	equence of):							
.O. Box (that the death certificate by ed by the attending physici detached for use as the bu	Physician/Medical	IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2 [9 ☐ Unknown	months? ⊒No		oirth 2 🗀 Fe nant at time o	tal déath 3	□ Ectopic pr □ Other <i>(spe</i>	opic pregnancy er (specify)			;	23d. Date of delivery Month Day Year	
rds, P.	es be be	by	Part II. Other signif	ficant condition	ns contributing to de	eath but not re	esulting in the u	underlying ca	use giv	en in Part I.		tobacco u Yes 2[the cause of death?
l Rec	The law ate has to bage 2 st	Completed									24a. Was auto perf 1 □ Yes		prior to c death?	topsy findings available ompletion of cause of
Vita	Physician: this certifica al director, p	Be	25. Was case refer examined?	red to medical	I lo anital:				100	26. Place of Dea				
of	di is	은	1 Tes 2 ☐ 27. Manner of Deat		Hospital: 1 🗆 I	<u> </u>	ER/Outpatie			4 🗆 Nursing F			6 ☐ Other (Spec	cify)
uo	Attending r death. ector: After by the funer	tion	1. Natural 2 Accident	5 ☐ Pending investiga	(Mon	th, Day, Year)	28b. Time of Injury	M 28	Bc. Injur Worl	y at k? Yes 2 □ No	28d. Describe	how injur	y occurred	
-=	ai or Atter s after dea il Director ed in by the	Certification:	3 Suicide 4 Homicide	6 Could no determin	ot be 28e, Place	of Injury - At ng, etc. <i>(Sp</i> e	home, farm, st	reet, factory,			28f. Location City or To	(Street an wn, State	d Number or Ru	ral Route Number,
:	To the Hospital or Attending Phewithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Medical C	29a. Certifier (Check only one)	1☐ Certifying 2☐ Medical E	Physician: To the xaminer: On the band mann	best of my ki asis of examinated.	nowledge, dea nation and/or i	th occurred a nvestigation,	at the til	me, date and plac opinion, death occ	e, and due to the urred at the time	e cause(s , date and) and manner as d place, and due	stated. to the cause(s)
_	Io the within 2 To the I complet	Me	29b. Signature and	title of certifier	11) confirm		29c.	Licens	e number		29d. Dat	te signed (Month	n, Day, Year)
			ghen	Lode	N /7/	3/4	90		H	2055 9	127	Kjer	117	2009
_			30. Name and addr	for a	ho completed caus	e of death (It	em 23a) (Type,	Print)	ta	(Drin	5 C	ever	4 re	myland
	Sta Registr	re.	31. Date filed (Mon	th, Day, Year) R 282(009 Bens	egistrar's Sigi	ool 14	Kal					01	

amend #29d Per PHY G890 4/28/09 JH
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician 3:15P April 17,2009 Mildred M. Bonadio /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Parkville Balto. Oakcrest Care Center If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** Days Months 1 □ M 2 🛣 F MARYLAND Director 89 May 19,1919 218-05-7804 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 7 is marked other than "natural", or items 23a or 28a-f sho≀ traumatic event, tra Medical Evaminer must be notified at 1 ☐ Yes 2 No Director Md. Balto. Parkville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21234 USA 8810 Walther Blvd. Apt 1430 Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Armed Forces?
1 ☐ Yes 2 [X] No
If Yes, Give
Year or Dates: Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene.

is marked other than "natural", or itel 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify. White þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8th Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bernard J. McNulty Mary B. Mueller ဂ္ Department of Health and Important: if item 27 is me any injury or other trauma once. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8810 Walther Blvd.Apt.1430 Parkville, Md. 21234 Vincent Bonadio Spouse 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4-21-2009 Most Holy Redeemer Balto.City, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Rd. Nottingham, Md. 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to (or as a chrisequence of): cerebrovascular disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy cate has been signed by the atte page 2 should be detached for Month Day Year 5 Other (specify) 9 Unknown)ovaClo, アルロル Division of Vital Records, F Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an autopsy performed 1 ☐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 3 🗆 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 4/17/2009 29b. Signature and title of certifier D61785 30. Name_and address of person who completed cause of death (Item 23a) (Type, Print) Walther Blud Parkville, MD 21234 8800 31. Date filed (N 2 ar) State Registrar

ber		1	Of. Zip Code			10g. C	itizen of What Co	untry?
ntclair D	Drive		21043			U	nited St	ates
ed 2 <mark>¼</mark> Married	12. Was Decedent Ever in U Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Year or Dates:		Decedent of h s, specify Cub Yes 2 No	Hispanic Origin? (San, Mexican, Pue Specify:	Specify Yes or rto Rican, etc.	No-	14. Race - Ame Black, White Specify: W	
15. Decedent's Ed fy only highest gra	ide completed)	16a. Decedent's (Give kind life. DO N	s Usual Occup of work done IOT use retire	during most of wo	orking	16b. I	Kind of Business/	Industry
idary (0-12)	College (1-4or 5+)			Manufact	urina		Manufac	turina
First, Middle, Last))			18. Mother's Na		ld <i>ie, M</i> aide		
Czincill	.a			F	rances	O'Nea	al	
me/Relationship (Type. Print)	19b. Mailing Ad	ddress (Street	and Number or F	Bural Route Nu	ımber, City	or Town, State, 2	Zip Code)
idra R. B	Sowman (Daughte	er) 124	Castle	Pines D	rive, A	Aledo	, Texas	76008
osition	Removal from State	Place of Disposition cemetery, cremato.	n (Name of ry or other pla	ce)	Date	20c. l	ocation - City or	Town, State
5 ☐ Other (<i>Specif</i>)		rest Law	n Gard	ens 04/	29/2009	Mari	riottsvi	lle, MD
neral Service Licer	Z. L		me and Addre		Hubbaro	Fune	eral Hom	e, Inc. land 21229
e disease, or com t failure. List only inal	plications that caused the dear one cause on each line. a. Due to (or as a consec	th. Do not enter th			ac or respirato	ry arrest,	29.	Approximate Interval Between Onset and Death
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pregnant nonths?	23c. If yes, outcome pf pregn 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of o	al death 3 ⊟Ecto	opic pregnanc ner <i>(specify)</i>	ry		_	23d. Date of del Month	ivery Day Year
cant conditions	contributing to death but not res	ulting in the underl	ying cause gi	ven in Part I.	23e. D	oid tobacco	use contribute to	the cause of death?
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ed to medical	Haanital		1	26. Place of De	eath (Check or	nly one)		
lo		ER/Outpatient 3	L DOA				6 □Other (Spe	cify)
5 ☐ Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju Wo M 1		28d. Øescr	ibe how inji	ury occurred	
6 ☐ Could not be determined	28e. Place of injury - At h building, etc. (Speci	ome, farm, street,	factory, office		28f. Location City or	on (Street a Town, Sta	and Number or Ru te)	ural Route Number,
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title of certifier 29d. Date signed (Month, Day, Year) 04/27/2009								
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Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2 X No

Maryland

2009

Howard

State Registrar

Medical

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

29b. Signature and title of certifie

Abdollah

31. Date filed (Month, Day, Year)

APR 28 2009

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State of Maryland / Department of Health and Mental Hygiene State of Per verbal, 8890,04/28/09dhb Reg. No. Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Gladys Conley Apri1 22 2009 5:55p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Carroll Hospice Dove House Westminster 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Florida 5. Social Security Number **Funeral** 1 □ M 2 🔽 F Days Hours 230-14-8753 86 Yrs. Director Aug 15 1922 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modifical Examiner must be norther an once. 10h. County 10a. State 10c. City, Town or Location 10d. Inside City Limits MD Howard Sykesville 1 ☐ Yes 2 ☐ No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21784 USA 1105 River Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes ≥ ☐ No if Yes, Give Λ Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Completed by Specify: 3 XWidowed 4 ☐ Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Elementary/Secondary (0-12) College (1-4or 5+) Agriculture payroll clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Caroline Jones Albert Booth ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1105 River Road, Sykesville, MD 21784 Mr. Gill Conley (son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🎇 Cremation 3 💢 Removal from State 4-24-09 4 ☐ Donation 5 ☐ Other (Specify) Northern Neck. Crem. Warsaw. VA 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Haight Funeral Home & Chapel Pargrafaght Herbert P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): 声 イス・ハート から Division of Vital Records, P.O. Box 68760 the Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Year Dav 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 2∐No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home Thesidence 6 Nother (Specify) Hospice 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗌 Homicide LC Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar > MKMZ ND

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1380

Progress

32 Registrar's Signatur

DHMH 17 Rev 1/2001

D 33681

Eldersburg MD

4-23-09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 4:25 Linda April 25, Conner 2009 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Joseph Richey Hospice Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Months Days Hours Min 219-08-3563 38 4-21-1971 Germany Usual Residence of Decedent 10b County 10c. City, Town or Location 10a, State 10d. Inside City Limits 1 □Yes 2 □ No Maryland Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21220 U.S.A. 27 Propeller Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐Yes 2 🔀
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) American Limousine Elementary/Secondary (0-12) College (1-4or 5+) Commercial Driver 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Monahan Carol Ann Brown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Father 27 Propeller Drive Middle River Md. 21220 William F. Monahan 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Removal from State 2 ☐ Cremation 3 ☐ Removal from State 4-29-2009 Middle River, Md. Holly Hill Mem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph N. Zannino Jr. F.H. 263 S. Conkling St. Balto. Maryland 21224 Enter ine diseas e or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Ust only one cause on each line. Approximate Interval Between Onset and Death shool Immediate C se (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 - Ectopic pregnancy in the past 12 mont Month Year Day 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No 1 □Yes 2 **∠**No 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes Other: 4 Nursing Home 5 Residence 6 Other (S 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Mann of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Accident 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

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ns 23a or 28a-f shormust be notified at

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Pages 1 and 2

Director

Funeral

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should be filed within 72 hours after death with the Maryland and Mental Hygiene.

Baltimore, Maryland 21215-0036

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Physician/Medical

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Certification: To

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Records,

Division of Vital Hospital or Attending Physician:

The law requires that the

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within 24 hours after death To the Funeral Director:

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of cer

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1/ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

6 ☐ Could not be determined

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Dav Year Rose Cin co 25 2009 5:45 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Bayview Care Social Security Number 8. Date of Birth (Month, Day, Year) July 29, 1946 . Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X** F Months Days Hours Min 219-50-7438 62 Director Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any linity or other traumatic event, the Medical Francisco. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 □ No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6731 O'Donnell Street Funeral 21224 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Yo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married Specify: White 1 ☐ Yes 2 🛣 No Specify: Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore County Elementary/Secondary (0-12) College (1-4or 5+) Schools 12 years Teachers Aide 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Wisner June Beach ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6731 O' Donnell Street, Baltimore, Maryland 21224 Salvatore Cincotta Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Sacred Heart of Jesus Cem. 20a. Method of Disposition 20c. Location - City or Town, State April 29. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 2009 Dundalk, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Part 1. Enter the disease of the cor heart failure. Lis complications that caused the death to not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) preumonia /Medical Due to (or as a consequence of): Examiner Due to (or as a conservence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗆 Ectopic pregnancy 4 Pregnant at time of death Year Day 5 ☐ Other (specify) 1 □Yes 2 □NO 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown disease coronary arte: Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Sternum 1 ☐Yes 2 ☐No 1 ☐ Yes 2 **1 N**o Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 140 ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Certification: 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

The law requires that the death certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-trar Division of Vital Records, P.O. Box 68760, or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, To the Hospital

> State Registrar

Medical

DHMH 17 Rev 1/2001

Michele F.

29a. Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Baysies Circle Battimore

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registral Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year 10300 M Κ. Chan Gabriel 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Northwest Hospital Seasons Hospice Randallstown Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1 □ M 2 🕏 K F Min. 213-60-3023 0ct 25, 1949 Hong Kong Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 ☐ Yes 2 ☑ No Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Sunspot Road 21136 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: 3 X Widowed 4 ☐ Divorced Asian 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lai Tao Lui Sui Hung Lui 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Priscilla Chin Daughter 607 Sunspot Road Reisterstown, MD21136 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/28/09 4 Donation 5 Dother (Specify) Lorraine Park Cem Woodlawn, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 11824 Reisterstown Road ELINE FUNERAL HOME Reisterstown, MD

Physician /Medical Examiner

Department of Health Important: If Item 27 any injury or other trong once.

Physician

/Medical

Examiner

10a. State

MD

Funeral

Director

28a-f show

ral", or items 23a or 28a-f show Examinations to notified at

Director

Funeral

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Completed

Be

2

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

3altimore, Maryland 21215-0036

Physician/Medical Examiner law requires that the death certificate be executed

burial-tran attending physician for use as the burial signed by the a d be detached for icate has been sig funeral director, After this within 24 hours after death To the Funeral Director: filled in by the

Be Completed by

Certification: To

Medical

Division of Vital Records, P.O. Box 68760.

To the Hospital or Attending Physician:

23a. Part 1. Enter the disease, or shock, or heart failure. List	complications that caused the death. Do no only one cause on each line.	ot enter the mode of dying, such as cardiac or res	spiratory arrest,	Approximate Interval Between
Immediate Cause (Final disease or condition resulting in death)	a. Non Small Due to (or as a consequence of	GII Lung Cancer		Onset and Death
Sequentially list conditions, it is a sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a sonsequence of):		
resulting in death) Last	Due to (or as a consequence of);		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of del Month	ivery Day Year

Advonal Mota	- A	ulting in the underlying	cause given in Part I.		se contribute to the cause of death?] No = 3			
Thrombocy topo	ma			24a. Was an autopsy performed? 1 ∐Yes 2 ☒No	24b, Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 ☒ No			
25. Was case referred to medical examiner?	26. Place of Death (Check only one)							
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 ☐ I	lome 5 ☐ Residence 6	SASONS ITOSPICE Specify)				
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occurred				
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, street, factory)	ry, office	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,			
29a. Certifier 1 Certifying Physics (Check only one) 1 Medical Exami	sícian: To the best of my kno ner: On the basis of examina	wledge, death occurre tion and/or investigation	ed at the time, date and place on, in my opinion, death occu	e, and due to the cause(s) urred at the time, date and	and manner as stated. place, and due to the cause(s)			

29b. Signature and title of certifier

29c. License number 144593

29d. Date signed (Month, Day, Year) April 22 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

re Sute 203 Baltimare MD 21201 2835 Smith

State Registrar

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 9:38 AM 200 /Medical Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner WASHINGTONNI RNIE ANNE HRUNDEZ Birthplace (State or Foreign Country) If Under 6. Sex Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1**√**¥M 2□ F Yrs Director MICHIGAN MAR. 20, 1945 382.46.9638 64 Usual Residence of Decedent death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or items 23a or 28a-f shov 1 ☐ Yes 2/1 No Director **PASADENA** MD ANNE ARUNDEI 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 126 MAGOTHY BRIDGE RD. 21122 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc. ORNELIUS, THOMAS filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√12 No Specify. WHITE Specify: 3 Widowed 4) Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CATERER A CRAFT ABOVE CATERING 12 7 is marked other traumatic event, 1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Health and Mental ၉ IVA THOMPSON MAURICE CORNELIUS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any injury or other trainonce. 433 MARYLAND AVE., PASADENA, MD AMY JO PANZER COMPANION 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) 4 ☐ Donatia BAYVIEW CREMATORY INC. APR. 21, 2009 BALTIMORE, MD U 22 Name and Address of Facility, P.A. ALL THE PROPERTY OF K. **GREGORY** FINK M01148 426 CRAIN HWY. S., GLEN BURNIE, MD 21061 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, o shock, or heart failure. complic to no that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one, a se on each line. Immediate Oruse (Final Physician Shoc Der TIC days disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner neumonia Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of Physician/Medical Exam attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of). IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Dyluman 1 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has autopsy certificate 1 □ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Division of Vital Records, P.O. Box 68760,

Hospital or Attending Physician: The law requires that the death certificate be executed ours after death.

eral Director: After this certific filled in by the funeral director, 24 hours a completely within 2

State

Medical

4 Homicide

(Check only one)

31. Date filed (Month, Day,

29a. Certifier

Vaclim

29b. Signature and title of certifie

Year)

**Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30/ Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

2. Registrar

Hospital

2009 MD

Registrar

P.O. Box 68760分 Division of Vital Records.

> State Registrar

DHMH 17 Rev 1/2001

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Sigrature

· S : DHARMASENA

APR 28 2009

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

M.D. 3721 POTEE St. BALTIMORE, MD 21225

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene = For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 25 CHEON 6 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Howard County General Hospital Columbia 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months Days 1 XM 2 ☐ F Hours Min. 12, 1929 Director China 79 215-76-8556 Usual Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Directo Baltimore Maryalnd Perry Hall 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 10813 Catron Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specity Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Asian If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: Completed by 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Chef Restaurant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cheung Ho Bin Ng Fung Yan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Cheung Son 7710 Briar Stone Court; Ellicott City, MD 21043 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Lorraie Park Cemetery 4/29/2009 | Woodlawn, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Sterling Asthon Schwab Witzke Funeral Home of Catonsville, Inc. LIC # MO1537 MD 21228 1630 Edmondson Avenue; Catonsville 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** HEMOPTYS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as e consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal deat
4 Pregnant at time of death 3 Ectopic pregnancy Month Year Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Hunknown Certification: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐Yes 2√No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☑ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day, Year) filled in by the funeral 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Lewan Kuch D 25004 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOWARD CO. GEN HOSP Columbia m =VAN RUEK 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 28 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Jovito Guillermo Roman Colon 12:40PM April 23,2009 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Baltimore Gilchrist Hospice Towson If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Date of Birth (Month, Day, Year) 3-7-1938 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 1**X** M 2□ F 582-58-2028 Puerto Rico Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits Baltimore Dundalk 1 Yes 2 No 10e Street and Number 10f Zip Code 10g. Citizen of What Country? 1902 Eastfield Road 21222 TICA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 【★No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Tes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 1XYes 2□No 3 ☐Widowed 4 ☐ Divorced Puerto Rican White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clothing Tailor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pilar Colon Gonzalez Jovito Roman Orlan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 21222 19a. Informant's Name/Relationship (Type. Print) 7018 Mornington Rd., Apt.B, Dundalk, MD Amarilys Roman- Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Ocremation 3 Removal from State Bayview Crematory 4-25-09 Baltimore, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Bradley-Ashton Funeral Home 21. Signature of Funeral Service License DITTALL 2134 Willow Spring Road, 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final emplications OF PARKINSON years disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Dother (Specify) Was Pre-1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of D ath 28d. Describe how injury occurred 5 Pending investigation 1 Natural

permit. Pages 1 and 2 should be filed. Department of Health and Mental Himportant; if item 27 is more any injury or other. **Physician** /Medical Examiner Division of Vital Records, P.O. Box 68760.

Physician

/Medical

Examiner

Funeral

Director

show

Director

Funeral

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Completed

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d other than "natural", or items 23a or 28a-f shovevent, the Mevical Examiner mans be notified at

death

filed within 72 hours after

al Hygiene.

3altimore, Maryland 21215-0036

cate has been signed by the attending physician page 2 should be detached for use as the buria

Physician/Medical

Completed

Be

Medical

2 Accident

4 ☐ Homicide

29b. Signature and title of certifier

3 ☐ Suicide

29a, Certifier

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oman, Jovito

filled in by the funeral Certification: To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu

> State Registrar

6 ☐ Could not be

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TECERTIFYING Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year) APRIL 23

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AMON CHANNES NiCharles ST TONSON NO 6701

31. Date filed (Month, Day, Year) 32. Registrar's Signature APR 28 2009

and manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 3444 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2009 Year Month Day \mathbf{p}^{M} Janet K. Christensen April 2:25 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Towson Gilchrist 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Min. 1 □ M 2√2 F Months Days Hours 61 216**-**56-3530 Feb 27 1948 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 ☐ Yes 2 ☐ No Hunt Valley Md.Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21030 USA 13C Warren Lodge Court 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Be Completed by 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cemetery Counselor Cemetery 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Eugenia Elizabeth Lennan William Joseph Kauffman 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13C Warren Lodge Court Hunt Valley, Md. 21030 Mr. Harry Leisher/ Friend Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5▼Other (Specientombment Gardens Of Faith Cem. 4-28-09 Baltimore, Md. 22. Name and Address of Facility
Ruck Towson Funeral Home, Inc 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final LUNG CANCER METASTATIC JULY 2008 disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28d. Describe how injury occurred 1 🔀 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide determined 4 ☐ Homicide

Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Physician/Medical Completed by page 2 should be After this certificate has of Vital or Attending Physician: Be Medical Certification: To after death To the Hospital o

Physician

/Medical

Examiner

Funeral

Director

72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, I'm Medical Evanting in ust by notified

Pages 1 and 2 should be filed within nent of Health and Mental Hygiene.

permit. Pages 1 and Department of Healt Important: If item 2 any injury or other once.

Physician

/Medical

Examiner

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D64395

APRIL 24,2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6565 NORTH CHAMES ST, SUTELOG BANDMORE, MD 21204 DANIEUE DOBERMAN, MO 31. Date filed (Month, Day, Year)

State Registrar 29a. Certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - State of Maryland / State Registrar		rtment of F tificate of			ene g. No. 200	9 13445		
Physic		1. Decedent's Name (First, Middle, Last) Michelle M. Deltuva		•		2. Date of Death Month April		3. Time of Death 2:50a M		
/Med Exam		4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	r Location of Death	Yhtit	4c. County of			
Funera		Gilchrist Hospice 5. Social Security Number 6. Sex 7. Age (In yrs. last I	hirthday)	TOWSO		8 Date of Birth		Birthologo (State or Foreign		
Directo		212-58-8911 1 M 2MF 58	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 1	Year) 1950	Birthplace (State or Foreign Country) MD		
/land		Usual Residence of Decedent 10a. State 10b. County 10c. City, To	wn or Loc	ation				10d. Inside City Limits		
ne Mar 8a-fsh	Director	MD	Ва	ltimore	9			1 ZYes 2 □ No		
th with th	ral Dire	9307 Old Court Road		10f. Zip Code 2124	4	100	g. Citizen of Wha	at Country? USA		
and 21215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. ad other than "natural", or items 23a or 28a-f show event, 1s. Malical Evant natural be notified at	by Funeral	11. Marital Status 1	lf '	as Decedent of F Yes, specify Cuba □Yes 2🛛 No	lispanic Origin? (Spe an, Mexican, Puerto f Specify:	cify Yes or No- Rican, etc.)		American Indian, White, etc. White		
15-(oletec	(Specify only highest grade completed)	(Give ki	ent's Usual Occup ind of work done o O NOT use retired	during most of working	16	6b. Kind of Busin	ess/Industry		
212 212 d withi giene. er thar	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 1.2 2	_	Owner Non-Profit				ofit		
laryland 2121 2 should be filed within and Mental Hygiene. Is marked other than aumatic event, to M	To Be (17. Father's Name (First, Middle, Last) Albert Deltuva			18. Mother's Name		aiden Surname) 11y			
IOCE, Maryla ges 1 and 2 should I it of Health and Men if item 27 is marke or other traumatic.	-				and Number or Rura	l Route Number, (City or Town, Sta			
Baltimore, Maryland 21215-0036 bernit. Pages 1 and 2 should be filed within 72 hours att Department of Health and Mental Hygiene. mportant: If item 27 is marked other than "natural", or any injury or other traumatic event, 13. Medical Evan proce.		Robin Deltuva / Daughter 8556 Davis Road, Columbia, MD 21045 a. Method of Disposition 1 Burial 2 Acremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Ardent Crematory 4/27/2009 Hanover, MD								
Baltimo permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee Dorota Marshal	7/ ²² .	Name and Addres		ion Sei	cvices			
bay 600, filtrate be executed Examiner by physician and Examiners the burial-transit	cal Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or complications). Due to (or as a consequence or complications).	onot enter	r the mode of dyin	ng, such as cardiac o	r respiratory arres	t,	Approximate Interval Between Onset and Death		
BOX eath cert attending for use a	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal deat 4 Pregnant at time of death		Ectopic pregnancy Other (specify)	У		23d. Date of Month			
HECONGS, P.O. te law requires that the de that been signed by the ge 2 should be detached	by	Part II. Other significant conditions contributing to death but not resulting	in the und	lerlying cause give	en in Part I.	100		te to the cause of death? Probably 4 Unknown		
VITAI NEC sician: The law r certificate has be lirector, page 2 sh	Completed					24a. Was an autopsy performe 1 □ Yes 2 L	prior deat	e autopsy findings available r to completion of cause of th? Yes 2 □ No		
ysicia ysicia is certi directo	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Outpatient	3 □ DOA Othe	26. Place of Death er: 4 ☐ Nursing Hom		o 6 Pothor /	Sand Horacia		
Attending Phy at death. ector: After this by the funeral or	tion: T	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year)	. Time of Injury	28c. Injury Work	y at 2	8d. Describe how		Specify)(7) o good		
To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification: To	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, f building, etc. (Specify)	farm, stree		Yes 2 □ No 2	8f. Location (Stree City or Town, S	et and Number o State)	or Rural Route Number,		
ne Hospita n 24 hours ne Funera pletely fille	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination a and manner stated.	ge, death o	occurred at the tinestigation, in my of	ne, date and place, a pinion, death occurre	nd due to the cau d at the time, date	se(s) and manne and place, and	3r as stated. due to the cause(s)		
To ti withi To ti comp	M	29b. Signature and title offertifier Ally cr	20	29c. License				S, 2009		
		30. Name and address of person who completed cause of death (Item 23a)	(Type, Pri	int) N. C	Charles	St. B	alto.	5,2009 Md 21204		
Sta Regist		31. Date filed (Month, Day, Year) 22. Registrar's Signature	park	w w						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-03083 State of Maryland / Department of Health and Mental Hygiene Steven Harold Dennard 2009 13446 Certificate of Death 1- For State Reg. No Registrar 3. Time of Death 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ April 17, 2009 2010 hrs Medical Examiner HAROLD STEVEN DENNARD c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Hyattsville 6205 Annapolis Road Suite 205 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Hours Country) Director NOV.11, 1960 GA 48 256.11.0525 1 X X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County any Yes 2 XX No s 23a or 28a-f show e notified at once. CANTON CHEROKEE with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 30114 2027 LOWER BURRIS RD. 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after death win nent of Health and Mental Hygiene. ant: If iten 27 is marked other than "natural", or items or other traumatic event, the <u>Medical Examiner must be 1</u> If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? Never Married 1 XXYes Specify: WHITE Yes 2 XXNo specify: If Yes, Give Yeer 1979-1983 4 XX Divorced ģ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 MECHANICAL / ELECTRICAL TECHNICIAN 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) VIVIAN ADEL PITTS HAROLD GRADY DENNARD Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) LOWER BURRIS RD., CANTON, GA 30114 SISTER 2027 JANET TWEEDIE 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Burial 2 XXCremation 3 XX Removal from State APR. 22, 2009 WEST GEORGIA CREMATORY AUSTELL. conation 5 Other Spe 10 A2 Name and Address of Facility P.A. ture of Funeral Service Import mag 426 CRAIN HWY. S., GLEN BURNIE, MD REGORY. FINK M01148 implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Part I. Enter the disease, dic 23a. Physician Between Onset and ach line lure. List on on cause on Death W dical Atherosclerotic cardiovascular disease Imme ate Cause (Fina disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and transit The law requires that the death cert ficate be executed X AMENDED #1,23a,27,perME, g890 4/29/09 TT Physician/Medical X UNPENDED attending physician or use as the burial -Box 68760, 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy Day 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Year Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. þ Yes 2 No 3 Probably 4 V Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? certificate har 2 No ✓ Yes 2 No 1 🗸 Yes 26 Place of Death (Check only one) the Hospital or Attending Physician: 25. Was case referred to medical Division of Vital Other₄ Hospital: Nursing Home 5 Residence 6 Other: Scene Inpatient 2 ER/Outpatient 3 this 1 ✓ Yes 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death Certification: 1 X Natural 1 Yes 2 No Pending death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) To the Funeral D Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie April 18, 2009 O.C.M.E. 20 a 01 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201

DHMH 17 Rev 1/2001 OCME 2006

State Registrar Carol Allan, MD

31. Date filed (Month, Day, Year)

egistrar's Signatur

OCME

Assistant Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			State of Maryland		rtment of l tificate of			giene Reg. No.?)	000	1011.7
	_		Registrar 1. Decedent's Name (First, Middle, Last)			Dodin	2. Date of De	ath	009	3. Time of Death
	Physici: /Medic		Vincent A. Do	broch	owski		Month April	23,	2009	5:14A M
3	Examin		4a. Facility Name (If not institution, give street and number)			or Location of Dea	ath	4c. County of Death Baltimore Co.		
-/	Funeral		225 Antietam Road 5. Social Security Number 6. Sex 7. Age (In yrs. las	st birthday)	Esse If Under 1 Year	If Under 24 Hi	rs. 8. Date of Bir	th		nplace (State or Foreign intry)
	Director		213-16-6866 ¹ X M 2□ F 86	Yrs.	Months Days	Hours Min	n. (Month, Da Aug • 1		2 Mai	ryland
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City,	Town or Loc	ation					10d. Inside City Limits
	Maryl a-f sho licd a	ţoţ	Maryland Baltimore			Es	sex			1 ☐ Yes 2 🔀 No
	or 282	Directo	10e. Street and Number		10f. Zip Code			10g. Citize	en of What Cou	intry?
	s 23a		225 Antietam Road	40.14	212		/O		ed Stat	
920	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinar must be redified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 □ No If Yes, Give Year or Dates: WWII		vas Decedent of Yes, specify Cub		(Specify Yes or No erto Rican, etc.)		4. Race - Amer Black, White Specify:	
Š	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)						d of Business/li	ndustry		
121	within ene. than "	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 8 Years	Weld		id)	g	Ste	el Indi	ıstry
Maryland 21215-0036	d be filed vental Hygic ced other c event, to	To Be Co	17. Father's Name (First, Middle, Last) Ignatius Dobrochowski			18. Mother's Name (First, Middle, Maiden Surname) Unkn. Antoinette			Jnkn.	
ary	2 should be f and Mental I is marked of aumatic eve	۴	19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	g Address (Stree	l t and Number or i	Rural Route Numb	er, City or	Town, State, Z	ip Code)
	and 2 lealth m 27 i		Michele Bruggeman (Daughter)		1 Oberon		ensington		20895	
altimore,	Pages 1 nent of H int: If iter iny or oth		FEIBURAL Z LI Cremation 3 LI Removal from State		sition (Name of natory or other pla		Date		ation - City or T	
	permit. Pages Department of Important: If it any injury or once.	1 2	4 □ Donation 5 □ Other (Specify) (Ho 11) 21. Sign, ure of the ral Service Licensee		1 Mem. G					ver, MD
Ö	21. Sign ure of Brail Service Licensee 22. Narge and Address of Facility Duda-Ruck Funeral Home of Dundalk 7922 Wise Ave. Dundalk, Maryland							21222		
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death	
1	Physician /Medical				card	al ir	rfarch	m		Thour
	Examiner		Due to (or as a consequent	nce m						
	pe #	iner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause, (Disease or injury	nae uf):						
30	ficate be executed physician and s the burial-transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequer	nce of):			<u> </u>			
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9	The law requires that the death certificate be executed the has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Medi	IF FEMALE:							
Division of Vital Records, P.O. Box	eath certifi attending for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? ↓ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □	eath 3□	Ectopic pregnan	су		23	d. Date of deliments	very Day Year
o.	the de	ysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of deal 9 ☐ Unknown 9 ☐ Unknown	un 5∟	Other (specify)					
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ord	een si	ted					- 10	/es 2 ⊡	No 3□ Pro	bably 4 🗋 Unknown
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g	sician: The law certificate has l irector, page 2 s		25. Was case referred to medical		-	00 Disease 5 D	1 □Yes	2 2 No	1 🗆 Yes	2 - N o
<u> </u>	ysicia iis cert direct	To Be	examiner? 1 Yes 2 Hospital: 1 Inpatient 2 EF	R/Outpatient	t 3 DOA Ot	35,000	eath (Check only of Home 5 Resid		Other (Spec	ifv)
0	ing Ph Viter th uneral	L:uo	27. Manner of Death 1 Hotural 5 Pending (Month, Day, Year)	8b. Time of Injury	28c. Inju Wo	ry at rk?	28d. Describe	now injury	occurred	,
Sio	ttendi death. stor: / the fu	icati	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At hom.	a farm etra]Yes 2□No	28f Location (Ptroof and	Number or Bu	ral Pouto Number
≥ O	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certifics completely filled in by the funeral director, p.	Certification:	4 Homicide building, etc. (Specify)				City or Tov	vn, State)		ral Route Number,
	e Hos 24 ho e Fune letely	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowle and manner stated.	n and/or inv	estigation, in my	ime, date and pia opinion, death oc	ce, and due to the curred at the time,	cause(s) a date and p	and manner as place, and due	stated. to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier		29c. Lic <i>e</i> n				signed (Month	
	, ,		* Stillathan			6960	3	Hpr	11 23	,2007
	341		30. Name and address of person who completed cause of death (Item 2 Dr. Chatham 9000 Franklin Square)			imore, M	iarvland	2123	7	
	Sta	te	31. Date filed (Month, Day, Year) 22. Registrar's Signatur	e fami			-J			
	Doniete	-	ADD OR 2000 Kleener D.	ALC: NO.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Month PRIC TRICIA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Howard County General Hospital Columbia Howard If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours Min. 1 □ M 2 🗓 F Days 522-24-1095 85 1923 Director June 12, Colorado Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21044 USA 5400 Vantage Point Road, Apt# 616 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify. <u>۾</u> 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed withir nent of Health and Mental Hygiene. Int: If item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lucille Beall Roy O. Samson 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 any injury or other tra 4 Agrams Lane Pittsford, NY 14534 Phyllis S. McCauley, Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 04/28/09 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. Baltimore, Maryland 21. Signature of Funeral Service Licensee Cremation Society Of Maryland, Inc. Thomas Gregor 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any leading cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and and burial-tra Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for Ye ar 4 ☐ Pregnant at time of death Day 9 Unknown signed by the Other significant conditions contributing to death but not resulting in the underlying cause given in Part i 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown funeral director, page 2 should Be Completed peen a 24b. Were autopsy findings available prior to completion of cause of death? Was an autopsy perform 2 1 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Ampatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Chatural 2 Accident 1 ☐Yes 2 ☐ No filled in by the Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

09-03305 Stella Eleftheriou Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

tella Eleftheriou		1- For State	ate of Maryland			nt of Hea		Ment	al Hy		Don No.	20	na	1	31.1.0
Physicia	_	Registrar 1. Decedent's Name (First, Middl	le,Last)						2	. Date of De	Reg. No. ath	20	3.	Time of E	Death
Medical Examir		Stella Angelos 4a. Facility Name (if not institution				Tab City	Town, or L	onation of		Month April 24,		Year	Dooth	1928 h	rs
		Franklin Square Hosp)			edale	ocation of	rDeath			Baltimore		У	
Funeral		5. Social Security Number	6. Sex 7. Ag	je (In yrs. I	ast birthda	ay) If Un Mon	der 1 Year ths Days	If Under	Min			(DD/YYYY)	9. Birthpl Foreign	lace (State	e or
Director		212-60-4952	1 M 2 X F	57		Yrs.	uis Days	Hours	, IVIII.	Oct.	20,	1951	Count	ry) Gre	ece
any	ŀ	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or	Location							10	Od. Inside	City Limits
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after de	by Fu	3 Widowed 4 Div	1 Yes 2	∧ No		1 Yes	2 X No	specify:				Specify:	whit	te	
5-0036 led within 72 hours a Hygiene. other than "natura th Medical Exami		15. Decedent's Education (Spe				cedent's Usua					16b. i	Kind of Busir	ness/Indu	ustry	
36 thin 72 te. than "	ompleted	Elementary/Secondary (0-12)	College (1-4 or	5+)	Hous	sewife	and M	/othe	r		Ow	n Home	٥		
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than	a	Peter Angelos								Papas					
○ 8 8 8 €	٢	19a. Informant's Name/Relations John Eleftheri		and		Mailing Addres						-			237
- p # g %	1	20a. Method of Disposition		20b.	Place of D	Disposition (N	ame of ceme			Date		Location - C			
imore Pages 1 ment of H tant: If i		1 X Burial 2 Cremation 4 Donation 5 Other Si		aic		or other plac wn Ceme			4/29	/09	Baltimore, MD				
Baltimore, permit. Pages I ar Department of Hee Important: Tite	ı	21. Signature of Furieral Service	License			22. Name an	d Address o	of Facility				1050	Yor	k Roa	
	_	23a. Part I. Enter the disease, or	Men .	I the death	Do not o	Ruck *					reast she	Tows			L204 ate Interval
Physician /Medical		failure. List only one cause	on each line.											Between (Onset and eath
Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a cons			roscie	rotic	caro	110Va	iscula	r di	sease	\dashv		
** **	<u>_</u>	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a cons	equence o	of)·								\dashv		
	miner	cause. Enter Underlying Cause (Disease or injury that initiated	c												
cuted and transit	Exa	events resulting in death) Last	Due to (or as a cons	equence o	of):										
exe	edical	X UNPENDED	AMENDED 23	a,27,	per l	ME G89	1 5/5/	/09 I	T						
760, ficate be g physic the burn	2	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome	me of preg	nancy	Tem.	. 2	Estania	pregnand		23	d. Date of de			Voor
Box 6876(: death certificate the attending physel	O	past 12 months?	4 Pregnant at	t time of de	eath 5	Fetal deat Other (Sp		Ectopic	pregnanc	У		Month	Day		Year
BO) he death	Physi	Yes 2 ✓ No 9 Uni Part II. Other significant condit	known g Unknown tions contributing to deat			فالمعادي عطاء		on in Da	41	220 Did	tobacca	use contribu	to to the	anus of	dooth?
ires that the d signed by the	Ē	Part II. Other significant condit	ions contributing to deal	n but not r	esulling ir	r the underlyin	ig cause giv	ven in Fai	t i.	1 Y		No 3			
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Division of Vital Records, P.O. Box 6876(To in 4 Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the beautiful to the funeral director.	Completed										opsy formed? 2 N	dea	ath? Yes	2	No -
ital Recition: The sector, page	Be C	25. Was case referred to medica examiner?					26.Place c		Check on						
F Vit	ျ	1 Yes 2 No 27. Manner of Death		ent 2 🗸		atient 3	DOA C	L		Home 5	_		Other:		
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Diversity of filled in	Certific	4 Homicide dete	ermined (Specify)							or Town,	State)				
To the Hospital within 24 hours:			hysician: To the best of maminer:On the basis of exa											ause(s)	
5 69 5 E E E E	Medical	29b. Signature and title of certific	and manner stated.				9c. License					Date signed			r)
		Me de	mell MZ	-			O.C.M	1.E.			Apr	il 25, 200	9		
		30. Name and address of person		,					1 2/3=		1				
		Melissa Brassell, MD	Assistant Medica			11 Penn S	Street, Ba	ltimore	, MD 2	1201					
Sta	ate	31. Date filed (Month, Day, Year)		ai s oignati	uie ∡2										

DHMH 17 Rev 1/2001 OCME 2006

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month April 23, ^{Day} 2009 **Physician** Mildred V. Faircloth AM 10:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Long Green Nursing Center Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Funeral 1 □ M X F Months Days Hours Min 213-20-2091 85 Director Nov. 19, 1923 Maryland Usual Residence of Decedent 10a. State 10b. County 10c, City. Town or Location 10d. Inside City Limits 28a-f show event, the Medical Examiner must be notified at MD Director Baltimore Parkville 1 ☐ Yes 2√No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 2446 Harwood Road 21234 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 220No If Yes, Give Year or Dates: or items, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 white 1 □ Yes 2√No Specify. þ Specify 3. Widowed 4 □ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Private Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) B George Freeman Clara Virginia Fidler မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Is r Marcella Maxwell-daughter 2446 Harwood Road-Parkville, Maryland 21234 Department of Health Important: If item 27 any injury or other to once. 20b. Place of Disposition (Name of cemetery, crematory or other place).
Dulancy Valley Memorial.
Carcens 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1XXBurial 2 ☐ Cremation 3 Removal from State April 27,2009 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 8800 Harford Road EVANS FUNERAL CHAPEL AND CREMATION SERVICES Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CARDIOVASCULAR ATHEROSCIEROTIC YEARS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) the 9 Unknown ģ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy certificate 200 No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after deatl To the Funeral Director: filled in by the 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) APRIL 27, 2009 031136 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KILBRIDE RD., BATIMORE, MID 21236 ALF MD 9005 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 298 tate of Maryland / Spparinest of Health and Mental Hygiene For A State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Calvin H. Fry April 2009 11 3:00 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Casey House Hospice Rockville Montgomery | ROCKVIIIC | If Under 14 Hrs. | 8. Date of Birth (Month, Days | Hours | Min. | Dec 23, | Dec 23, | Dec 23, | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Compan 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months 1924 1 ☑ M 2 □ F 84 165-22-7040 Pennsylvania Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the World Eventing must be notified at 1 ☐ Yes 2 ☐ No Funeral Director MD Howard Fulton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7534 Cherry Tree Drive 20759 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ∰Yes 2 □ No
1 Yes, Give Year or Dates:

1 43-46 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Completed by Specify: white 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) salesperson carpeting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James H. Fry Rachel Clarissa Manners ۴ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia Fry/spouse 7534 Cherry Tree Drive Fulton, MD 20759 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ₩ 5 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 4 Donation 5 ☐ Other (Specify) 21. Signature of Fundam Service L 22. Name and Address of Facility Sixector State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Rart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Lause (Final **Physician** recurrent pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 D Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown nis certificate has been signed by director, page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by dementia 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy After this certificate 2 No 1 TYes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1∐Yes 2⊡No Other: 4 Nursing Home 5 Residence 6 Other (Specify) + while 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 🗆 Yes ours after death 2 Accident 2 🗆 No the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 6 within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Kouertchou, mx DO063747 Jocetyne April 28, 2009

12+1

29030

31. Date filed (Month, Day, Year) State APR 28 2009 Registrar

Jocelyne Kouatchou, 6001 Muncaster Mill Road, Rockville, MD 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

amend item 5 oP Marylane 890 4-29-09 of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Jonathan David Feldesman 24 April /Medical Feldesman 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death a Hospital Baltmore Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8 Date of Birth (Month, Day, Year) **Funeral 1** M 2 □ F Months Days Hours Min. 219-46-6181 Director 3/7/1947 62 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location Is marked other than "natural", or items 23a or 28a-f show aumatic event, the "Midical Evati, from must be notified at Director MD Baltimore Jone Harn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 2350 Flax Terrace 21209 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 XNever Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify 3 Widowed 4 Divorced Completed 3 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 s 1 and 2 should be filed withir of Health and Mental Hygiene. Item 27 Is marked other than College (1-4or 5+) Homemaker Own Home Kullun 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jackson Feldesman Gladys Tepper ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Winston G. Davis / Companion 2350 Flax Terrace, Baltimore, MD 21209 Ottient permit. Pages 1 a
Department of He
Important: If item
any injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Ardent Crematory 4 ☐ Donation 5 ☐ Other (Specify) 4/27/2009 Hanover, MD 21. Signature of Funeral Service Licensee Dorota Marshall 22. Name and Address of Facility
Maryland Cremation Services · Moustus PO Box 1413, Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Intracrania /Medical Due to (or as a consequence of): Examiner Hypertenene if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Inneral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) ☐Yes 2-☐No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by Drabeter mellitu 24a. Was an 25. Was case referred to medical examiner?
1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA 27. Manne of Death
1 Natural
2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

23d. Date of delivery Month 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES- OUT MD April 24,2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) Jinai 32 Registrar's Signature APR 28 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

Birthplace (State or Foreign Country)

White

Approximate Interval Between Onset and Death

lday

2009

USA

14. Race - American Indian, Black, White, etc.

6:58 PM

D.C.

1X Yes 2 □ No

10d. Inside City Limits

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2009 April 26, Gloria Marie Ferro 9:55 P M 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 7412 Alvah Avenue Apt F Baltimore Dundalk Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 1 □ M 2 🔀 F Months Days Hours Min. December 28, 1935 73 219-32-0920 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2X No Maryland Baltimore Dundalk 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 7412 Alvah Avenue Apt F 21222 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: Specify:White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 years Registered Nurse Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Mario F. Ferro Josephine M. Goles 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raymond F. Ferro Brother 512 Patapsco Avenue, Rosedale, Maryland 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) April 30 20c. Location - City or Town, State IX Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery Dundalk, Maryland 2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final IN FARCTION MYOCARDIAL disease or condition resulting in death) MINUTES Due to (or as a consequence of): DISEASE ATHENZOSCLE POTIC CAMPIONASCULAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? AORTIC STENOS15 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ATMIAL FIBRILLATION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2000No 1 TYes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Physician /Medical Examiner Examiner

Physician

/Medical

Examiner

Funeral

Director

show

Director

Funeral

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Completed

Be

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d other than "natural", or Items 23a or 28a-f shov event, the Maxical Examinat must be notified at

death

filed within 72 hours after

12 should be filed within hand Mental Hygiene. 7 Is marked other than "1

1 and 2 s Health an

permit. Pages 1 am Department of Heal Important: If item 2 any Injury or other

traumatic

other

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-transit the ģ s been signed b should be deta cate has t page 2 s certificate director, this

After thi

Physician/Medical

2

Completed

Be

Medical Certification: To

4 Homicide

29a, Certifier (Check only one)

requires that the death certificate be executed Box 68760. P.0. Division of Vital Records, ospital o. 24 hours after dea. ••eral Director: Afte

To the Hospital or Attending within 24 hours after us To the Funeral Direct

State Registrar

29b. Signature and title of certifier

determined

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

030377

09

BALTIMORE MD

PARKHEIGHTS AVE MO 6503

POBERT M. COOPER 31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

State

Registrar

APR 28

Mahlon

Fisher

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 5-A M APRIL OHA W ORBES 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 9. Birthplace (State or Foreign BAZTIMORE REHABILITA MON EXTENDED If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) If Under 1 Year 6. Sex Social Security Number Year) Months Days Hours 1 X M 2 □ F Alabama 173-16-5801 87 September 5, 1922 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State Baltimore Parkville 1 Yes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 USA 2906 Kings Ridge Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No WWII If Yes, Give Year or Dates: 14. Race - American Indian. 11. Marital Status Black, White, etc 1 □ Never Married 2 □ Married 1 □ Yes XXXNo White Specify. Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Builder of Prosthetic Devices Self Employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Irene Lulu Mudd John J. Forbes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2700 Cowan Boulevard Apt 228 Fredericksburg VA 22401 Teresa Forbes/Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ℓ Baltimore National Vacem. 04-29-2009 Baltimore, Maryland ^{22. Name and Address of Facilit}inc. 5305 Harford Road Baltimore Maryland 21214 21. Signature of Funeral Service License bruh 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final NGESTIVE HEART disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if y leading to the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? MELLITUS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No FIBRILLATION 24a. Was an autopsy performed? 25. Was case referred to medical 26. Place of Death (Check only one)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral Director

Completed by

Be

2

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any lojury or other traumatic event, the Medical Evanner must be notified at once.

Saltimore, Maryland 21215-0036

the burial-tran Hospital or Attending Physician: The law requires that the death certificate be exect physician Division of Vital Records, P.O. Box 68760, attending pl cate has been signed by the page 2 should be detached certificate has

Physician/Medical Examiner Completed by Be Medical Certification: To n 24 hours after death.

Be Funeral Director: Af

funeral director,

completely

within 2

10

After

1 Yes 2 ☑ No

27. Manner of Death

1 Natural

2 Accident

3 Suicide

(Check only

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 5 Pending investigation

28b. Time of 28c. Injury at Work?

Other: 4 Mursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

BATIMORE

6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 vertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3900 LOCH RAVEN BOULEVARD MO MILLER

31. Date filed (Month, Day, Year) State Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 26, ROSALIE CONNOLLY 10:05 A.^M April 2009 4a. Facility Name (If not Institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Baltimore Stella Maris Hospice Timonium if Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan. 2, 19 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) Months Days Hours Min. 1 □ M 2 🕅 F 93 212-09-7198 1916 Maryland Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2300 Dulaney Valley Road 21093 <u>U.S.A.</u> Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry

(Give kind of work done during most of working life. DO NOT use retired)

Alice

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Timonium,

Date

4-28-09

TIMONIUM, MD 21093

Auto Parts

20c. Location - City or Town, State

te signed (Month, Day, Year)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

4 Unknown

HOSPICE

Baltimore, Maryland

18. Mother's Name (First, Middle, Maiden Surname)

Cochran

Maryland

Factory Worker

240 Chantrey Road

20b. Place of Disposition (Name of cemetery, crematory or other place)

Green Mount Crematory

Physician /Medical Examiner

Department of Health Important: If item 27

1 - For State Registrar

10a State

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

19a. Informant's Name/Relationship (Type. Print)

4 ☐ Donation 15 ☐ Other (Specify)

JACKIE JONES, CRNP

APR 28 2009

1 ☐ Burial 2 X Cremation 3 ☐ Removal from State

10 years

Francis

Joan A. Fox

20a. Method of Disposition

Physician

/Medical

Examiner

Funeral

Director

ral", or items 23a or 28a-f shov Examiner must be notified at

mjury or other traumatic event, the Medical

Maryland 21215-0036

Baltimore,

Directo

Funeral

Completed by

Be

The law requires that the death certificate be executed physician and s the burial-trans To the Hospital or Attending Physician: within 24 hours after death

To the Funeral Director:
completely filled in by the

Division of Vital Records, P.O. Box 68760.

	21. Signature of Funeral Service Licen	ellurse	22. Name and A Mitchel 6500 Y	Address of Facility 1-Wiedefelork Road	d Funeral H Baltimore,	ome, Inc Maryland	· 21212		
	shock, or heart failure. List only	plications that caused the death. Do no one cause on each line.					Approximate Interval Between Onset and Death		
	Immediate Cause (Final disease or condition resulting in death)	a. LUNG CANCER Due to (or as a consequence of):				Onset and Death		
miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b Due to (or as a consequence of):						
lical Exa	resulting in death) Last								
Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1								
ed by Pr	Part II. Other significant conditions of	ontributing to death but not resulting in t	he underlying caus	e given in Part I.	23e. Did tobacco		the cause of death?		
Complet	24a. Was an autopsy performed? 1 □ Yes 2 ■ 2 ■ 1 □ Yes 2 ■ 1 □ Ye								
36	25. Was case referred to medical examiner?				ath (Check only one)				
	1 ☐ Yes 2 📉 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outp	patient 3 DOA	Other: 4 I Nursing I	Home 5 Residence	6X Other (Spec	ify) HOSPIC		
ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	(Month, Day, Year) Inj	28a, Date of Injury 28b, Time of 28c, Injury at 28d, Describe how injury or						
Medical Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, of	fice	28f. Location (Street a City or Town, Sta	and Number or Rui te)	al Route Number,		
edical	29a. Certifier (Check only one X Nurse Pract	ysiclan: To the best of my knowledge, niner: On the basis of examination and ition	death occurred at /or investigation, in	the time, date and place my opinion, death occ	e, and due to the cause urred at the time, date a	(s) and manner as nd place, and due	stated. to the cause(s)		
5	and as a state of them		00 /						

ss of person who completed cause of death (Item 23a) (Type, Print)

College (1-4or 5+)

Connolly

(daughter)

DHMH 17 Rev 1/2001

State

Registrar

2300 DULANEY VALLEY RD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. L 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year L1: 389M Eva Laverne Gemmell 2009 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death (+) Agre 0501 270 n/a 0 9 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Months Days Hours 1 □ M 2 🛛 F Yrs. Director 217-20-0883 83 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show show Funeral Director MD Baltimore Baltimore 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Item 27 Is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must but 5720 Mineral Avenue 21227 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc illed within 72 hours after 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 □Yes 2 No Be Completed by Specify. White Specify: 3 ℃ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home Pages 1 and 2 should be filed v nent of Health and Mental Hygic ant: If Item 27 Is marked other: 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Sautter, Sr. Eva Blottenburger ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lloyd J. Gemmell, Jr. / Son 815 Misty Meadow, Sykesville, Maryland 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page Department of Important: If any injury or once. injury or 1 Buriol 2 Cremation 3 Removal from State 5 ☐ Other (Specify) Meadowridge Mem. Pk. 4/29/2009 Elkridge, Maryland ign ture o Funeral Service License 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Pair 1. En er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** atheroselerot cass resulting in death) /Medical Due to (or as a consequence of): Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): physician Box 68760 Physician/Medical attending ph IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mon
1 ☐ Yes 2 No Month 5 ☐ Other (specify) Ö the 9 Unknown 9 Unknown þ ۵. cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ş 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Division of Vital 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 2 Accident 5 Pending investigation 1 ☐Yes 2 ☐ No within 24 hours after death

To the Funeral Director; completely filled in by the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 90

State Registrar

DHMH 17 Rev 1/2001

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 13459

	1- For State Certificate Registrar Certificate	of Death				
Physician/ Medical Examine	1. Decedent's Name (First, Middle, Last)	2. Date of Deat Month April 22, 2				
(David Gambill 4a. Facility Name (if not institution, give street and number)	April 22, 20 4b. City, Town, or Location of Death	4c. County of Death			
	117 Boyd Drive	Annapolis	Anne Arundel			
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 1 M 2 F 44	Marchael Barrel Harris Little	5 1964 9. Birthplace (State or Foreign Country) CA			
any	Usual Residence of Decedent 10a. State	ocation	10d. Inside City Limits			
*	MD Anne Arundel Annapo	lis	1 Yes 2 X No			
ith the Maryland 23a or 28a-f sho notified at once.		10f. Zip Code 21403	og. Citizen of What Country? USA			
er death w or items r must be Funera	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year	3. Was Decedent of Hispanic Origin? (Specify Yes or No- lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 X No specify.	14. Race - American Indian, Black, White, etc. Specify: White			
hours aft "natural" Examine	45 December 1 Committee (Committee to the bound of the Committee to the Co	edent's Usual Occupation (Give kind of work done	16b. Kind of Business/Industry Department of			
5-0036 ed within 72 hour tygiene. other than "natu the Medical Exar	Eiementary/Secondary (0-12) College (1-4 or 5+)	ing Most of working life. DO NOT use retired)	Health & Human Serv.			
5-003 ed withi tygiene other th	17. Father's Name (First, Middle, Last)	18 Mother's Name (First, Middle, Maiden Surname)				
Q 13 & 12 & Q	Burt Gambill		laine Lasak			
MD 21 dd 2 should 1 dth and Mer nu 27 is mar nu 27 is mar	Patricia E. Gambill, mother 459	lailing Address (Street and Number or Rural Route Num 2 Nueces Drive, Santa Barl	para, CA 93110			
Baltimore, MD 2 permit. Pages I and 2 shou Department of Health and N Important: If iten 27 is n injury or other traumarite	1 Burial 2 X Cremation 3 Permoval from State crematory	isposition (Name of cemetery, or other place) rematory, Inc. 04/24/2009	20c. Location - City or Town, State Baltimore, MD			
Balti permit. Departu Import injury		² Cremation Society of Mary 299 Frederick Road, Balt	vland, Inc. imore, MD 21228			
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not en		est, shock, or heart Approximate Interval			
/Medical ¬xaminer	failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Narcotic (oxymorp Due to (or as a consequence of):	hone and morphine) intoxio	Between Onset and Death			
ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):					
ted Insit Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause C: Due to (or as a consequence of):					
760, icate be executed by physician and the burial - transit	d.					
'60, ate be exect physician an be burial - tr		perME G891 5/14/09 TT				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans edical Certification: To Be Completed by Physician/Medical E.	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 4 Pregnant at time of death 5 9 Unknown	Fetal death 3 Ectopic pregnancy Other (Specify)	23d. Date of delivery Month Day Year			
ords, P.O. w requires that the s been signed by t should be detache			bacco use contribute to the cause of death? 2 No 3 Probably 4 V Unknown			
Division of Vital Records, tal or Attending Physician: The law requires as after death. al Director: After this certificate has been signed in by the funeral director, page 2 should be striffication: To Be Completed	·	24a. Was autop	sy prior to completion of cause of med? death?			
of Vital Recoing Physician: The law After this certificate has uneral director, page 2 s or: To Be Compl	25. Was case referred to medical	1 ✓ Yes 26.Place of Death (Check only one)	2 No 1 Yes 2 No			
1 of Vital I ling Physician: After this certifi funeral director, on: To Be C	examiner? 1 V Yes 2 No Hospital: 1 Inpatient 2 ER/Outpa		Residence 6 Other: Scene			
ion of ttending F death. :tor: After / the funer ation: '	1 Natural 5 Pending Fd 4/22/09 Fd 1	:15 pm ¹ Yes 2X No unk	now injury occurred			
Division o To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral of	$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$	street, factory, office building, etc. ome 28f. Location (\$ or Town, \$ Annapo	Street and Number or Rural Route Number, City tate) 117 Boyd Dr Lis, MD			
To the Hos within 24 h To the Fur completely	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death one) 2 Medical Examiner: On the basis of examination and/or inveand manner stated.					
2	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) April 23, 2009			
		111 Penn Street, Baltimore, MD 21201				
State Registrar		hadel	15.			
DHMH 17 Rev 1/2001	ORIG	INAL				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 U () 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Month. Year 4730 pm 7000 Francis George Guerke /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Washington Medical Center 0 150 mit If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Pay, If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 → M 2 □ F Months Days 217-12-5152 Director 02/13/1925 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at Director Maryland Anne Arundel Co. Glen Burnie 1 □Yes X□No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 7571 Baltimore & Annapolis Blvd NE 21060 United States Funeral items 12. Was Decedent Ever in U.S. Armed Forces? XXYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. XMYes 2☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 X No Baltimore, Maryland 21215-0036 'natural", or Specify. ģ Specify. 3√Widowed 4 ☐ Divorced WWIT White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Electrician Branch Manager US Naval Academy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Danie1 W. Guerke Marie Lilly Kahline 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. David W. Guerke / Son 8179 Forest Glen Dr. Pasadena, Maryland 21122 20a. Method of Disposition
1 ☐ Burial 2 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date injury or 4 ☐ Donation 5 ☐ Other (Specify) 04/25/2009 Atlantic Crematory Glen Burnie, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility any ir Singleton Funeral & Cremation M01121 Services PA; 1 2nd Ave SW, Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-trar or Attending Physiclan: The law requires that the death certificate be exec Due to (or as a consequence of): 68760 Physician/Medical attending pl Box IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) o 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown funeral director, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform Vital 1 □Yes 1 □Yes 2 □ (o 25. Was case referred to medical 26. Place of Death (Check only one) 1 | Yes 2 | No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA 1 npatient ot this 28a. Date of Injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No after death Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifie 29c. License number 0

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type

TCO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month John Edward Gregory, Jr. **Physician** 838PM 40Ri 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A of Baltimore Baltimore Hospital City If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 28 Yrs. 8. Date of Birth 1 0 / 22 / 80 Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months 1**⊠** M 2□ F 216-98-3678 MD Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 28a-f show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a f show any Injury or other traumatic event, the Medical Examinar must be notified at any Injury or other traumatic event, the Medical Examinar must be notified at once. Baltimore MD N/A 1 XYes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21215 USA 3804 Wabash Ave-Apt. #T4 Funeral death v 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. African 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify Specify American <u>수</u> 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) School 8 Student 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Angela Tomin John E. Gregory, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1814 Maryland Ave, Balt., MD 21202 Angela Tomlin?Mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Pages 1 5/2/09 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Balt.,MD Mt. Zion Cem. 4 ☐ Donation /5 ☐ Other (Specify) 22. Name and Address of FacilityHari P. Close F.S., PA 5126 Belair Rd, Balt., MD 21206-5105 21. Signature of Ineral Service Littense 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Se od ay **Physician** , /Medical Due to (or as a consequence of): Immunodeficiency Syndrome Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Duelto (or as a consequence of): b. Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
24 hours after death.
b. Funeral Director: After this certificate has been signed by the attending physician and etely filled in by the funeral director, page 2 should be detached for use as the burial-transit etely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Box 68760, IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No PNEUMON 24a. Was an autonsy performed 2 1 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28b. Time of Injury 27. Manper of Death Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only and manner stated. within 2 29d. Date signed (Month, Day, Year)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day,

30. Name and address of berson who completed cause of death (Item 23a) (Type, Print)

TOPIN

KNOWA

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Vear **Physician** 10:28AM M Roscoe Gibson 2009 /Medical <u>April</u> 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton

der 1 Year | If Under 24 Hrs. Prince Georges

9. Birthplace (State or Foreign Country) 6. Sex 1 M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Year) Min. Davs Hours Months 226-12-4236 87 Director 18, 1921 Virginia April Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ir than "natural", or Items 23a or 28a-f sho Director 1 ☐ Yes 2 No DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 3335 Clay Street NE 20019 Funeral Dist. of Columbia 12. Was Decedent Ever in U.S. Armed Forces? V☐Yes 2☐No IfYes, Give Year or Dates: uknown 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Item any Injury or other traumatic event, Its Medical Exar Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify ģ Specify: Black 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Shipping Transportation Truck Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Gibson unknown ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gerald Gibson Son 11301 Old Propspect Hill Road Glen Dale, MD 20769 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5▼Other (Specify) instate 21. Signature of Funeral ervice Licensee Ronald S. Wade 22. Name and Address of Facility State Anatomy Board 655 West Baltimore Street 222 Baltimore, MD 21201 23a. Rart1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Ven DISCOSE **Physician** Un Known /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner and r s a consequence of) burial-t Due to P.O. Box 68760 attending physician death certificate be Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy for Day Month Year 4 Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No the detached 9 Unknown 9 Unknown signed by The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ģ g. 3 Probably 4 → hknown 2 🔲 No 1 □ Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an certificate has 1 ☐ Yes 2 110 Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔲 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated To the title of certifi 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) mpleted cause of death (Item 23a) (Type, Print) Name and add s of person State 8 Registrar

amend #263627 Per Pht. 6890 4/28/09 III State of Maryland Department of Health and Mental Hygiene O O 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of DeatlApr. 24, 2009 10:40 Death **Physician** Month Sandra Gottsagen /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 35 STONEHENGE CIRCLE #3 BALTIMORE BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth July 25 1937 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2(X)F 224-44-5797 VIRGINIA 71 Yrs Director Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Experient must be received at Director MD BALTIMORE 1 □Yes 入□No BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 35 STONEHENGE CIRCLE #3 21208 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 【 No Specify: ģ 3 Midowed 4 □ Divorced Specify: WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry Beine butter use retired) Elementary/Secondary (0-12) College (1-4or 5+) BENIFITS COORDINATOR SOCIAL SECURITY ADMIN. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Health and Mental em 27 is marked o MAX KAPLAN SELMA **BOBER** ဂ 19a. Informant's Name/Relationship (Type. Print)
KAREN KATZ/DAUGHTER 19b Mailing Address (Street and Number of Eural Route Number, City or Town, State Zip Code) 350 TVY KNOLL, NE ATLANTA, GEORGIA 30342 Department of Heat Important: If item 2 any injury or other 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2014 Received of Garden Order Park Date 20c. Location - City or Town, State Pages 1 AMUNO CONG. 4/27/2009 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician Due to (or as a con equence of): Artery DISEASE disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 ☐ Other (specify) ned by the a 1 Tyes 2 No. 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Fibrillatter 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown page 2 should Hypertension 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy Wyperlipidemia
25. Was case referred to medical examiner? certificate 1 □ Yes 2 No funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Affer 28d. Describe how injury occurred Hospital or Attending 1 X X atural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No after deat Director; filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide n 24 hours at 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the I the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) April 25 2009 30. Name and address or person who completed cause of death (Item 23a), (Type, Print)

Crang Gold Do 1838 Greene Tree hand 135 Batti more, Maryland 31. Date filed (Month, Day, Year) APR 28 2009 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Arthur Kenneth Gaines, Jr. 1- For State Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ 1527 hrs April 19, 2009 **Medical Examiner** Arthur Kenneth Gaines, Jr. 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore Harbor Hospital Center If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) g. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Hours Min. Months CountryMaryland Director 216-98-5096 1 X M 2 38 Yrs 12/19/1970 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State Yes 2 XNo Maryland | Anne Arundel Brooklyn Park 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 253 Rupert Circle United States 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married 2 Married Yes 2 X No Specify: White Pages I and 2 should be filed within 72 hours after of nent of Health and Mental Hygiene. ant: If item 27 is marked other than "matural", or Yes, Give Year Yes 2X No specify: Divorced 3 Widowed marked other than "natural", c event, the Medical Examiner 2 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) MD 21215-0036 Home Improvement 12 Laborer 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Arthur Kenneth Gaines, Sr. Patricia Louise Spencer Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 253 Rupert Circle Brooklyn Park, Maryland 21225 Patricia L. Harr - Mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Crestlawn Memorial 04/23/2009 Sykesville, Maryland 22. Name and Address of Facility
David J. Weber Funeral Homes P.A.

401 S. Chester Street Baltimore, Maryland 21231

Part I. Enter the disease: a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart

Approximate Interval failure. List only one cause on each line. Important: Signature of Funeral Service Licensee **Physician** We dical a Narcotic (heroin and methadone) intoxication Immediate Cause (Final disease .aminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last r and transit sician/Medical 23a,27,28a-f,perME, g891 5/11/09 TT tending physician a XUNPENDED The law requires that the death certificate be Box 68760, 23d Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 2 Fetal death Month Year 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown 9 Unknown the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 V No 3 Probably 4 Unknown ş σ. Completed Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy ector, page 2 shu death? performed? ✓ Yes 2 1 🗸 Yes 2 Νo 26.Place of Death (Check only one) Hospital or Attending Physician: funeral director. 25. Was case referred to medical Division of Vital Other, Hospital: 1 Nursing Home 5 Residence 6 Other: Inpatient 2 V ER/Outpatient 3 this 1 Yes No 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year 28b. Time of Injury After 27. Manner of Death Certification: Natural 1 Yes 2 X No unk Pending 4/19/2009 within 24 hours after death.

To the Funeral Director: unk the Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc filled in by 6 X Could not be Suicide unk determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Func 29a. Certifier (Check only Medical ✓ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie April 20, 2009 O.C.M.E. tell 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Laron Locke MD. 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001 **OCME 2006**

Registra

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - For State Registrar	ate of Maryland	•	artment of h			rgiene Reg. No. 2 1 1 1	131,65	
Physicia		1. Decedent's Name (First, Middle, Last) Robert E. G	riffin			<u> </u>	2. Date of De Month	path Day Year 23 2009	3. Time of Death 21:13 M	
/Medic Examine		4a. Facility Name (If not institution, give street Good Samar, ton h	and number)		4b. City, Town, o			4c. County of Dea		
Funeral Director		5. Social Security Number 6. Sex 218 56 1348 1 M 2	7. Age (In yrs. le	a <i>st birthd</i> ay) Yrs.	If Under 1 Year Months Days	If Under 24 Hi Hours Min	8. Date of Bir n. (Month, Da May 2		thplace (State or Foreign ountry)	
/land		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits	
e Mar	Director	MD n/a		Bal	timore				x [□] Yes 2□No	
with th	Dire	10e. Street and Number	C+		10f. Zip Code	213		10g. Citizen of What Co	ountry?	
If yielling Z Z 35-0030 should be filed within 72 hours after death with the Maryland and Mertle Hygiene. Ind Mertle Hygiene. In marked other than "natural" or items 23a or 28a-f show umatic event, the Modical Evantina	Funeral	Ar	as Decedent Ever in U.S med Forces? Yes 2 No	6. 13. V			(Specify Yes or No erto Rican, etc.)			
3-0030 72 hours af natural", or	ē	3 ☐ Widowed 4 ☐ Divorced Ye 15. Decedent's Education	Yes, Give ** ear or Dates:	16a. Deced	I □Yes 2√ No lent's Usua! Occup			Specify: b1		
tthin 72 Tan "n Medi	Completed	(Specify only highest grade complete (Specify only highest grade complete) Elementary/Secondary (0-12)	pleted) ollege (1-4or 5+)	(Give life. L	kind of work done OO NOT use retire	during most of w d)	orking			
iled w Hygiel ther ti		12th 17. Father's Name (First, Middle, Last)			disable		ame (First Middle	n/a Maiden Surname)		
id be file lental Hi ked oth Ic event	To Be	James Griffin					a Hardy			
i, Mal yiallu Z and 2 should be filed w eaith and Mental Hygie n 27 is marked other t her traumatic event, th	Ė	19a. Informant's Name/Relationship (Type. Pr Troy Griffin (son						per, City or Town, State, CO, Md. 212		
Datum Pages 1 and 2 should begant. Pages 1 and 2 should begantment of Health and Menimportant: if then 27 is marke any Injury or other traumatic. Once.		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State								
permit. I Departm Importar any Inju		21/Signature of Funeral Service Licensee	Luga	/ C	alvin E	3. Scru	.ggs Fun	ieral Home		
Dhysisian		23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cau	is that caused the leath se on each line.						21213 Approximate Interval Between Onset and Death	
Physician /Medical Examiner		resulting in death)	Due to (or as a consequ	ence of):						
nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unisease or injury that intitated events c	Due to (or as a consequ	ence of):						
interpretation and the purish transit	dical Exa		Due to (or as a consequ	ence of):			· · · · · · · · · · · · · · · · · · ·			
ortificate ing physical as the l	Medic	IF FEMALE:			-					
To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	ysician/Me	23b. Was decedent pregnant in the past 12 months?	yes, outcome of pregnar □ Live birth 2 □ Fetal □ Pregnant at time of de □ Unknown	death 3	Ectopic pregnand Other (specify)	cy .		23d. Date of de Month	livery Day Year	
w requires that the de been signed by the should be detached	d by Phy	Part II. Other significant conditions contributi	ng to death but not resu	iting in the ur	nderlying cause giv	en in Part I.		tobacco use contribute to	,	
he law requires t e has been signe tge 2 should be o	Completed						24a. Was autoj	psy prior to death?	utopsy findings available completion of cause of	
ltar: T	a	25. Was case referred to medical				26. Place of D	1 ☐ Yes eath (Check only o		3 2 ⊠No	
Physic eral direc	٦ 8	examiner? 1 ☐ Yes 2 ☑ No Hospita	1 M Inpatient 2 L I		t 3 DOA Oth	er: 4 🗆 Nursing	Home 5 ☐ Resi	dence 6 Other (Spe	ocify)	
Attending P attending P r death. ector: After the funeral	Certification:	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Inju Wor	ryat k? Yes 2 ∐No		how injury occurred		
ital or Att rs after d al Direct led in by 1	Certifi	3 Suicide 6 Could not be 4 Homicide determined 286	e. Place of Injury - At hor building, etc. (Specify	me, farmi, stre	eet, factory, office		28f. Location (. City or To	Street and Number or R wn, State)	ural Route Number,	
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s	Medical	29a. Certifier 1 ✓ Certifying Physician (Check only one) 2 ☐ Medical Examiner: C	: To the best of my known the basis of examinat and manner stated.	wledge, death ion and/or in	vestigation, in my	opinion, death oc	ce, and due to the curred at the time,	cause(s) and manner a date and place, and due	s stated. e to the cause(s)	
To t To t	≥	29b. Signature and title of certifier JENGOL M	D		29c. Licens			29d. Date signed (Mont		
		30. Name and address of person who complet	ed cause of death (Item	23a) (Type, I	Print) Food	-000 Sama	riton H	04-23	2009	
		Natallia Maroz, 56 31. Date filed (Month, Day, Year) APR 2.8 2009	01 Loch A	equen	Blvd,	Baltin	nore, M	D 21239		
Stat Registra	e ir	ADD 2.8 2009	62. Hegistrar's Signat	are par	de la					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Day Month Year Hennigan E April 2009 24 4b. City, Town, or Location of Death 4c. County of Death Parkville Baltimore 6. Sex If Under 1 Year | If Under 24 Hrs. | 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Aug. 17, 1922 Days Min. Months Hours 1 M 2 □ F Maryland 86 10b. County 10c. City, Town or Location

1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** ames 12:09PM /Medical 4a. Facility Name (If not institution, give street and number) Examiner 8810 Walther Blvd. Apt. 1229 5. Social Security Number **Funeral** 9. Birthplace (State or Foreign 217-18-6117 Director Usual Residence of Decedent with the Maryland 10a. State show 10d. Inside City Limits r 28a-f sh MD Baltimore Parkville Director 1 ☐ Yes 🏋 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ?7 is marked other than "natural", or items 23a or traumatic event, the Predict Examinar must be a Apt 1229 880 Walther Blud, 21234 Funeral death USA 12. Was Decedent Ever in U.S. Armed Forces? 1 X Xes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21/21/No Specify: \$ white Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) State Of Maryland Auditor 12 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be f Health and Mental John W. Hennigan Annie Judge ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra Frank Lidinsky-Attorney 8600 Lasalle Road-Towson, MAryland 21286 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State nlace 1 Disturial 2 Cremation 3 Removal from State New Cathedral Cemetery Apr. 30, 2009 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee EVANS FUNERAL 8800 Harford Road parkville,MD 21234 CHAPEL andia AND CREMATION SERVICES 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Acute disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Physician: The law requires that the death certificate be executed burial-Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4 ☐ Pregnant at time of death 9 ☐ Unknown Day Year 5 ☐ Other (specify) signed by the a I be detached f 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗖 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 Was autopsy performed? Vas 2 🗷 No certificate 2 No 1 ☐ Yes 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🗷 Residence 6 Other (Specify) 1∐Yes 2. No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? After 28b. Time of 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 ☐ Pending investigation 24 hours after death. Funeral Director: A 2 Accident 1 ☐ Yes filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 ☐ Homicide Medical

Division of Vital Records, P.O. Box 68760, completely the within To the

	Daniang, etc. (Operaty)		City or Town, State)						
Medical Examiner:	n: To the best of my knowledge, death occ On the basis of examination and/or investig and manner stated.	urred at the time, date and place, and pation, in my opinion, death occurred	d due to the cause(s) and at the time, date and place	manner as stated. e, and due to the cause(s)					
29b. Signature and title of certifier	ffax	29c. License number HOOSZ063	_	ed (Month, Day, Year)					
30. Name and address of person who comple Ron 10 Je ffreys, 0.0.	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ron 10 Jeffreys, DD. 8800 Walther Blod. Parky le May land 21234								
31. Date filed (Month, Day, Year)	32. Registrar's Signature								
APR 28 2009 Sen	we S. fall								

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep	artment of Health and ertificate of Death	, ,	2000 121.67
			Registrar 1. Decedent's Name (First, Middle, Last)	illicate of Death	Reg.	No 2 0 0 9 1 3 4 0 1
	Physici		Mary A. Hershfeld		Month	Day Year 5:50 p ^M
Mark	/Medid Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Deat		4c. County of Death
-			Charlestown Care Center	Catonsville		Baltimore
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9 Birthplace (State or Foreign
	Director		083-22-5667 1 M 2X F 82 Yrs. Usual Residence of Decedent		3/28/19	27 Maryland
	land w		10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
	Mary Ff sh	ģ	MD Baltimore Catons	ville		1 ☐ Yes 2 🛣 No
	h the	ie	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
	th wit	a a	713 Maiden Choice Ln.	21228	11	SA
	r dea	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert		14. Race - American Indian, Black, White, etc.
36	safte ",or i	by F	1 ☐ Never Married 2 ☐ Married ☐ 1 ☐ Yes 2 ☐ No	1 ☐Yes 2X No Specify:	0 1 110211, 010.7	Specify: White
21215-0036	should be filed within 72 hours after death with the Maryland and Mental Hygiene. § marked other than "natural", or items 23a or 28a-f show maric event, the Modical Eventher in the notified at unatic event, the Modical Eventher is used to notified at		3 ☐ Widowed 4 ☑ Divorced Year or Dates: 15. Decedent's Education 16a. Dece	edent's Usual Occupation	166	. Kind of Business/Industry
75	in 72 In "na Madis	Completed	(Specify only highest grade completed) (Give	e kind of work done during most of wor DO NOT use retired)	king	. Kind of business/industry
2	d with giene gr tha	ĕ	Elementary/Secondary (0-12) College (1-4or 5+) Teac	cher	P	ublic Schools
g	e filed al Hygi sother vent,	Be	17. Father's Name (First, Middle, Last)	18. Mother's Nan	ne (First, Middle, Maid	
<u>ya</u>	2 should be filed within and Mental Hygiene. is marked other than aumatic event, the Me	မ	Charles P. Hershfeld	Mary	L. Roan	e
	2 sho			ng Address (Street and Number or Ru		
	ss 1 and 2 should of Health and Mer item 27 is marke other traumatic			West Maple Road, 1		
-	Pages nent of int: If ite		TE bullar 2 Cleriation 3 E Removal from State	osition (Name of matory or other place)	.	. Location - City or Town, State
	permit. Page Department of Important: If any injury or once.	l) i		Crematory 4/24	/2009 Ba	ltimore, Maryland
Ba	Dep Impo	a i		2. Name and Address of Facility Hu		
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en	ter the mode of dying, such as cardiac	or respiratory arrest.	pre, Maryland 21229 Approximate
- F	Physician	8	Immediate Cause /Final	3		Interval Between Onset and Death
	/Medical		disease or condition resulting in death) Due to (or as a consequence of):	d130000		leas
	Examiner		Sequentially list conditions b			
	sit ed	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying			
	and and II-tran	хап	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
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20	certificate be executed ding physician and ise as the burial-transit	edical	d			
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	death le atten ed for us	sicia	1 Dives 2 No. 4 Pregnant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)		Month Day Year
ָר ה	ar me 1 by tf stache	hys	9 Unknown			
S,	e taw requires that the death certific has been signed by the attending to e 2 should be detached for use as	þ	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacc	to use contribute to the cause of death?
ecords,	requi	Completed			1 Tes	No 3 Probably 4 Unknown
	has t	nple			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
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5	g rmy er this eral d	2	27. Manner of Death 28a. Date of Injury 28b. Time o	f 28c. Injury at	ome 5 ☐ Residence 28d. Describe how in	6 ☐ Other (Specify)
Sion	ath. r: Aft	텵	1 Natural 5 Pending (Month, Day, Year) Injury 2 Accident investigation	Work? M 1 □Yes 2 □ No		jury socuriou
	er de:	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (Street	and Number or Rural Route Number,
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Hoen	The interpretain a werening rinysterion. The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	edical	29a. Certifier (Check only one) Medical Examiner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place vestigation, in my opinion, death occur	, and due to the cause rred at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)
Ę	withir Сотпр	Me	29b. Signature and title of certifier	29c. License number	29d. I	Date signed (Month, Day, Year)
			Just ma Tax	D30989	An	11 22 2009
			30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)		ril 22 2009 noville MD 21228
	Stat	0	31. Date lied (Month, Day, Year) 32. Registrar's Signature	raiden Choice	ru cat	85512 am alliven
	Registra		ADD 28 2009 Person D. Back			

HART, JAMES

Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Division of Vital Records, P.O. Box 68760, ate has been signed by the page 2 should be detached funeral director, After this after death.

I Director: Af
d in by the fu filled in by within 24 hours a completely

28a-f shov

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items 23a

"natural", or

Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

6 ☐ Could not be determined

4 Homicide

(Check only

29b. Signature and title of certifier

29a. Certifier

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number P20659

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ST. AGNES HOSPITAL, HAFSA KHAN, 900 CATON AVE., BALTIMORE, MD. 21229 31. Date filed (Month, Day, Year)

State Registrar

Medical



09-03	235 .
Louis	Harvey

ouis Harvey	State of Maryland / Department of Health 1- For State Certificate of Death	
Physician/	Decedent's Name (First, Middle, Last)	Reg. No. 2. Date of Death Month Day Year 1709 bear
ledical Examine	2003 110 VC4	April 22, 2009 1708 hrs n, or Location of Death 4c. County of Death
	3927 Woodridge Road Baltimor	. 1 / 0
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1	Dave Hours Min . Foreign
	217 - 44 - 7438 1 M 2 F 54 Yrs. World's Usual Residence of Decedent	Nov. Zle, 1955 Country) Mary land
м япу	10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
Maryland 28a-f show I at once.	10e. Street and Number	
the Maryland a or 28a-f sh	3924 Colharne Rd 0	21229 USA
leath with the Maryland leath with the Maryland streems 23a or 28a-f she tust be notified at once unsteal Director	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married Armed Forces? 1 Never Married 2 Married Armed Forces?	of Hispanic Origin? (Specify Yes or No- uban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
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hours aft		cupation (Give kind of work done glife. DO NOT use retired)
5-0036 ed within 72 hour tygiene. other than "natu the Medical Exar	Elementary/Secondary (0-12) College (1-4 or 5+)	
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director		18.Mother's Name (First, Middle, Maiden Surname)
2121: 2121: Juld be fi Mental J marked ic event,		Street and Number or 'ural Route Number. City or T State. Zip Code)
MD d 2 show tth and a 27 is tummation	Junist J. Harvey - brother 3924 Co.	Iborne Rd, Bostimae, MD
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical To Be Comple	20a. Method of Disposition 20b. Place of Disposition (Name of Communication of Communication State) 20b. Place of Disposition (Name of Communication of Communi	
	45 Donation 5 Other Specify: King Memorical 71.3 nature of Funeral Service Licensee 22. Name and Add	
Balti permit. Departi Import injury	Pora 1 porello 4600 L	iberty Heights Ave, BGHO. MD 2125
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xaminer	Immediate Cause (Final disease or condition resulting in death) a. Hypertensive atherosclerot Due to (or as a consequence of):	cic cardiovascular disease Death
<u>.</u>	Sequentially list conditions, b.	
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Ex late of Ex	I d	
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68760, certificate be riding physic se as the buritian/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death	23d. Date of delivery 3 Ectopic pregnancy Month Day Year
Box 6876: death certificat the attending phydfor use as the rysician/M	past 12 months? 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown	
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Div To the Hospital or within 24 hours aft To the Funeral Di completely filled in		
Med Son Table	and manner stated. 29b Signature and title of certifier 29c. Lie	cense number 29d. Date signed (Month, Day, Year)
	(I artorlesse)	O.C.M.E. April 23, 2009
d	30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Ba	altimore, MD 21201
State	31. Date filed (Month, Day Year) 32. Registrar's Signature	
Registrar	APRAD BUUS DENGEN P. MATTER	

				Please	Type or Prin					-	_	
		•	1 - State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. N						- 0000	3 13470		
	Physicia /Medic		Panald I Hamibal					2. Date of Death Month April	Day Year 2009	3. Time of Death 7:00 A _M		
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	Funeral		14206 Pho 5. Social Security Nur	mber 6. S	ex 7. Ag	e (In yrs. las	t birthday)	If Under 1 Year		8. Date of Birth	9. Bir	thplace (State or Foreign
	Director		219-34-05 Usual Residence of D	36	□ X (12□F	71	Yrs.	Months Days	Hours Min.	Aug. 8	1937	MD
	yland how			10b. County		10c. City, 7	Town or Lo	cation				10d. Inside City Limits
	ne Mar 18a-f sl	Director	MD	Baltimor	·e	Phoe	nix					1 □Yes 2 No
	a or 2	I Dir	10e. Street and Numb		/e.			10f. Zip Code	21131	10	g. Citizen of What Co USA	·
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2-002p	2 hour		1	15. Decedent's Ed	ucation]		dent's Usual Occup			6b. Kind of Business	/Industry
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Mar	and 2 should be ealth and Menta n 27 is marked her traumatic ev		19a. Informant's Nam Betty V.								City or Town, State, MD 2113	
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allimor	permit. Pages 1 ar D. partment of Hee Important: If Item any Injury or othe		4 ☐ Donation 5	Other (Specify	/)	1	aney	Valley A	Memorial (Gardens	Timonium	, MD
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	ital or Atturs after de ral Directo	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	building, et	c." (Specify)		eet, factory, office		City or Town,		
	the Hosp hin 24 hou the Fune mpletely fi	Medical	one)	∠ Medical Exan	ysician: To the best niner: On the basis o and manner st	r examinatio	edge, deati n and/or in	vestigation, in my	opinion, death occu	rred at the time, da	ite and place, and du	e to the cause(s)
)	vit O O	_	29b. Signature and tit	1	M	u	10	29c. Licens	52090	5	O $4/25$	th, Day, Year)
* T	Sta	te	30. Name and address 31. Date filed (Month)	J Dru	1724	eath (Item 2 AC ar's Signatur	100	W M	0 5	TWC	7601 Osler	Dr., Towson
	Registr		AP	R 28 200			400	relat				

		For State Registrar 1. Decedent's Nam	e (First, Middle	ə, Last)		Cei	rtificate of	Death	2. Date of D	eath	Von	3. Time of Death
Physici:		Margaret	L.	Hellmann					April	22,	2009	12:15 P
Examin	_			n, give street and nun	nber)			or Location of Dea	th		ounty of Death	
		Augsburg			7. Age (In yrs. las	t hirthday)	Gwynn C		S. 8 Date of B		altimor	
Funeral Director		5. Social Security N 213-26-6 Usual Residence o	271	6. Sex 1 M 2 AF	81	Yrs.	Months Days			928	MD	place (State or Foreig Intry)
f show		10a. State	10b. County Baltir			n Oak						10d. Inside City Limit 1 ☐ Yes 2 🛣 N
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al riygi d other svent, i	Be	17. Father's Name							ame (First, Middl		u <i>mam</i> e)	
marked communication	၉	Conrad O							le Buett		Y C1-1- 7	i- C-4)
E 20 E		19a. Informant's N Carol Al		ship (Type, Print) c/daughter				tand Number or F ive newa			iown, State, Z	IP Code)
ent of Health it: If Item 27 y or other tr		20a. Method of Dis 1 ⊠ Burial 2 4 □ Donation	Cremation	3 □Removal from :	State Cre	ce of Dispo netery, crea Stlaw	osition (Name of matory or other plan n Memoria	al Apr	. 25		iotsvi	
Department Important: If any injury o		21. Signature of F	uneral Service	License ()			2. Name and Addr		nbrose F	uneral	L Home	Inc.
		23a. Part1. Enter shock, or hea Immediate Cause	the disease, o art failure. Lis	r complications that conty one cause on e	aused the death. ach line.	Do not en	ter the mode of dy	ing, such as cardi	ac or respiratory	arrest,	IS MD 2	Approximate Interval Between Onset and Death
ysician Medical caminer	ner	Sequentially list of any, teading to cause. Enter Und Cause (Disease of		b	or as a conseque	nce of):	fancual	16 6	incer			Jean
physician and s the burial-transit	lical Examiner	Cause (Disease o that initiated event resulting in death)	15	c. Due to (or as a conseque	nce of):					<u> </u>	
by the attending phystached for use as the	Physician/Medi	IF FEMALE: 23b. Was deceded in the past 12 1 ☐ Yes 27 9 ☐ Unknown	2 months?	1☐Live b	come of pregnand irth 2 Tetel di ant at time of dea own	eath 3[□Ectopic pregnan □ Other (specify)	ey		. 23	3d. Date of deli Month	very Day Year
pe de	þ	Part II. Other sign	ificant condit	ions contributing to de	eath but not result	ing in the u	ınderlying cause g	iven in Part I.		d tobacco us]Yes 2		the cause of death?
Division of Vital Records, P.O. Box 687 or Attending Physician: The law requires that the death certificate after death. Burector, After this certificate has been signed by the attending phys in by the funeral director, page 2 should be detached for use as the partitication: To Be Commissed by Physician/Medicinarion: To Be Commissed by Physician/Medicinarion:	Completed								24a. We aut per	topsy rformed?	prior to death?	topsy findings available completion of cause of
certificate rector, pag	BeC	25. Was case refe	erred to medica	al				26. Place of D	eath (Check only	v one)		-
vision of Vita Attending Physicien: cleath. ector: Atter this certific by the funeral director, lification: To Be (examiner? 1 Yes 25	≸ No ath			R/Outpatie	of 28c. Ini	ury at	Home 5 Re 28d. Describ			city)
ath. r: After th	atlor	1 Natural 2 Accident		igation	th, Day Year)	Injury		ork? ⊒Yes 2□No				
Division C To the Hospital or Attending P within 24 hours after death. To the Funeral Director; Attert completely filled in by the funera Medical Certification:		3 🗌 Suicide 4 🔲 Homicide	6 Could deten	minor 200. Flace	of Injury - At hom ng, etc. <i>(Specity)</i>	ne, farm, st	reet, factory, office			(Street and own, State)	Number or Ru	rai Route Number,
within 24 hours after deatl To the Funeral Director; completely filled in by the	Medical C	29a. Certifier (Check only one)	1 Certifyi 2 Medice	ng Physician: To the Exeminer: On the b and man	best of my know asis of examination ner stated.	ledge, dea on and/or in	th occurred at the nvestigation, in my	time, date and pla opinion, death oc	ce, and due to th curred at the time	ne cause(s) a e, date and p	and manner as place, and due	stated. to the cause(s)
within To the somple	Me	29b. Signature an	d title of certifi	er			29c. Lice	se number			signed (Monti	h, Day, Year)
					_)		0375	73 isterte	1/10	5 /v	3,2009
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State of Maryland / Department of Health and Mental Hygiene 🤈 🖺 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** APRIL 2009 ROSE RITA HORNACK 7:30 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care Rossville Rossville Baltimore Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 M 200 F Director 213-09-5027 7, 1913 95 Nov. Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2√2 No Directo Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2630 Calvary Road 21015 USA Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 → No Specify: Specify. 3 Widowed 4 Divorced White 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ges 1 and 2 should be filed within it of Health and Mental Hygiene. If item 27 Is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Michael J. Holewinski Injury or other traumatic ၉ Mary (nmn) Stefan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary C. Taylor / Niece 2630 Calvary Rd. Bel Air, Maryland 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☑ Burjal 2 ☐ Cremation 3 ☐ F 4 ☐ ☑ Onation 5 ☐ Other (Specify) 3 Bemoval from State Department of Important: If any Injury or Sacred Heart of Jesus 4-27-09 Baltimore, Maryland McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 21. Signature of Funeral Ser 23a. art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be execute attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an this certificate mear: 2 ☐ No 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Man er of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred or Attending Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide within 24 hours a

To the Funeral L Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1813 Wallham Woods Road. MD 21234. completed cause of death (Item 23a) (Type, Pri State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Box 68760.5

P.0.

Division of Vital Records.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 22, 20019 Month AFRIL **Physician** 10:10F M ROBERT WILLIAM HEINLEIN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Baltimore Examiner Center Joseph Medical Towson 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Months Days Hours Min ty M 2 ☐ F Director 216-28-8646 23, 1932 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at 1 □Yes 2√2 No Directo Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1701 Earl Drive 21015 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 IXYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ➡No Specify. ğ Specify. 3 ☐ Widowed 4 ☐ Divorced White Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life_DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Computer Operations Specialist Steel Manufacturer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 27 is marked or traumatic ev John J. Heinlein Agnes Lillian Melka ۵ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley C. Heinlein / 1701 Earl Drive, Bel Air, Maryland 21015 Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H
Important: If ite
any Injury or ot
once. 1 ☑ Burial / 2 ☐ Gremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem. 4-27-09 Timonium, Maryland 21. Signature of Funeral Service Li McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 rt . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between hock, or heart failure. List only one cause on each line Onset and Death Imm diate Cause (Final **Physician** ACUTE EXACERBATION OF CHRONIC OBSTRUCTIVE DAYS disease or condition resulting in death) /Medicai Due to (or as a consequence of): Examiner PULMONARY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) pital or Attending Physician: The law requires that the death certificate be executed ours after death.

Heral Director: After this certificate has been signed by the attending physician and filled in by the functeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No 2 No 1 ☐ Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 1 Yes 2 No Hospital: 1 npatient Certification: To 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State

Baltimore, Maryland 21215-0036

P.0.

of Vital Records,

Division

DHMH 17 Rev 1/2001

Registrar

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30. Name and address of person who completed cayse of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

D 25886

DRIVE TOWSON MARYLAND

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2009 WILLIAM CONRAD HAFER /Medical 4a. Facility Name (If not institution, give street and number) Social Security Number 106. Sex 4b. City. Town, or Location of Death 4c. County of Death Examiner xar ford Birthplace (State or Foreign Country) In vrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** 1 € M 2 □ F Months Hours Min. Director 61 4, 1947 213-46-3334 Aug. Maryland Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, Ital Modical Examiner must be notified at Director 1 ☐ Yes 2 X No Maryland Harford Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1610 Ashby Square Funeral Apt. K 21040 12. Was Decedent Ever in U.S. Armed Forces? 1XYes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Black, White, etc. 1 Never Married 2 Married 21215-0036 If Yes, Give Year or Dates: 1 □Yes 2√2 No Specify: Completed by 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Loan Officer Morgage Company Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry (nmn) Hafer Blanche Elaine Fuller Jr. ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Henry Hafer III / Brother 3005 Duncan Road, White Hall, MD 21161 Department of Health Important: If item 27 any injury or other trong once. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition Pages 1 1 ☐ Burial 2 ☐ remation 3 ☐ Removal from State Hilltop Service Corp. 4-25-09 4 □ Donation 5 □ Other (Specify) Towson, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear trailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Dronary Hrkry
Due to (or as a consequence of): ilhknown disease or condition resulting in death) /Medical Examiner pertension Unknown Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner the burial-tran Due to (or as a consequence of) Box 68760 use as t IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 □ Yes 2 □ No ō 5 Other (specify) P.0. cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No autopsy or Attending Physician: The certificate perform 1 □Yes 2 No funeral director, 25. Was case referred to medical Certification: To Be 26. Place of Death (Check only one) caminer? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death After t 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 24 hours after deat Funeral Director: filled in by the 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Nedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) within 2 29c. License number 29d. Date signed [Month, Day, Year) 29b. Signature and title of ce 30. Name and address of person w

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

Anount P

, M.D., VA Maryland Health Care System, Perry Point, mD 21902

o completed cause of death (Item 23a) (Type, Print)

32. Régistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. Z Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** APRIL 25, 2009 GEORGE VINCENT HAMMEN JR. 8:30 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALITIMORE STELLA MARIS HOSPICE TIMONIUM If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1⊠M 2□ F Director 1925 Maryland 219-12-9484 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, Ite Medical Examinar must be notified at Director 1 ☐ Yes 2 XNo Maryland Harford Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 361 Blackburn Place 21085 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☑ No þ Specify. 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Postal Carrier Postal Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Vincent Hammen Sr. Frances (unk) (unk) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health a Important: If item 27 is any Injury or other trau 361 Blackburn Pl., Joppa, MD 21085 Amelia Marie Hammen / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Service Corp: 4-27-09 4 ☐ Donation 5 ☐ Other (Specify) Towson, Maryland 21. Signature of Funeral Service Licensee McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) ATORY **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical phys the L nding p 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy for Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has be irector, page 2 s autopsy performe 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 XNo **Division of Vital** the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 NOther (Specify SPICE Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide 24 hours a Funeral I 29a. Certifier

(Check only Check only NOCKE PLACTITION As and manner stated.

Con the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Check only Check only Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DUCANCY U

Registrar
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31. Date filed (Month, Day,

APR 28 2009

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

MD

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Funeral

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Completed

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Funeral

Director

show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 23 is marked other than "natural", or items 23a or 28a-f show any in jury or other traumatic event, it., Medical Exprision. The state in ordinal any in jury or other traumatic event, it., Medical Exprision.

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-trar page 2

that the death certificate be execu

the Hospital or Attending Physician; The

within 24 hours after death

To the Funeral Director:
completely filled in by the

Division of Vital Records, P.O. Box 68760,

by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	H100	2 days 30 minutes		
hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		opic pregnancy ner (specify)		23d. Date of delivery Month Day Year
Completed by Pt	Part II. Other significant conditions	contributing to death but not resulting in the under	ying cause given in Part I.		o use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
	25. Was case referred to medical		00.81	1 ☐ Yes 2 🔽 N	lo 1 ☐ Yes 2 ☐ No
o Be	examiner?	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3	26. Place of Death		C 🗆 Other (O 1/1)
Medical Certification: To	27. Manher of Death N Natural 2 Accident 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	28c. Injury at Work? 1 □ Yes 2 □ No	3d. Describe how inj	ury occurred
Certific	4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, f building, etc. (Specify)	, factory, office 28f. Location (Street and Number or Rural Route City or Town, State)		
edical	29a. Certifier 1	hysician: To the best of my knowledge, death occ miner: On the basis of examination and/or investi- and manner stated.	urred at the time, date and place, and gation, in my opinion, death occurred	nd due to the cause d at the time, date a	(s) and manner as stated. nd place, and due to the cause(s)
Σ	29b. Signature and title of certifier	BY MD	29c. License number	7.13	ate signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

Dr. Battimore, MD 21237

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SGranEb

31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #16a&19b Per FH C890 4/28/09 Jh State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death HERMAN Year **Physician** BENTAMIN APRIL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner SINAI HOJPITAL OF BALTMORE BALTIMORE BALTO. CIT If Under 1 Year If Under 24 Hrs. 8. Date of Birth MARCH 23, 7 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 □X M 2 □ F ,^{Yea}1915 217-05-2015 MARYLAND Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evanina mant house. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Director MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5833 PARK HEIGHTS AVE. #216 21215 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: <u>ک</u> Specify: 3 Widowed 4 □ Divorced WHITE Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NODistrict bution Elementary/Secondary (0-12) College (1-4or 5+) SPECIAL DISTRUBITION OFFICER US POSTAL SERVICE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be DAVID **HERMAN** RACHEL LOWMAN မ 19b. Mailing Nicites Francis at Number of Rural Route Number City of Town, State Zip Code) 3313 NORTH MOUNT ROAD BALTIMORE, MARY LAND 21244 19a. Informant's Name/Relationship *(Type, Print)* ROCHELLE BLUMBERG/DAUGHTER 2011 See of Disheld NA Hame of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1. Burial 2 ☐ Cremation 3 ☐ Removal from State AITZ CHAIM 04/27/2009 BALTIMORE, MD 5 ☐ Other (Specify) Aral Seryi 22. Name and Address of Facility SOL LEVINSON & BROS., INC. <u>8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</u> 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ACUTE RENAL FAILURE **Physician** disease or condition resulting in death) DAYS /Medical Due to (or as a consequence of): Examiner DISEASE EARS HRONIC Equalitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examine To the Hospital or Attending PhysIclan: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) been signed by the s 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown STENOSIS 24b. Were autopsy findings available prior to completion of cause of death? certificate has triector, page 2 sl 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this c Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation ours after death.

neral Director: Af
filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 37333 APRIL 23,2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE HOSPITAL OF AVI SINAI 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar APR 28 2009

Division or Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)



30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2434 W, BELVEDERE AVENUE

MD

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SURAITA , BALTIMORE

BELLUM

, MD -

04-26-2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 1530 eivo. TOHNSON 2009 25 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Baltimore Bayview Baltimore MD Hopkins If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 XM 2 ☐ F Director 213-42-3921 Usual Residence of Decedent 64 Maryland 07/26/1944 10a. State 10h Count 10c. City, Town or Location 10d Inside City Limits Show Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examination and the modified at 1XYes 2 □ No Baltimore Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1304 Anglesea Street # 1B 21224 U.S.A. death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. Armed Forces? Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or iter Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Black If Yes, Give Year or Dates: Specify 2 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cafeteria Worker School System 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ Mason Johnson Bertha Thomas 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 is any Injury or other trau 404 North Chapel Street, Baltimore, Maryland 21231
Per of Disposition (Name of Date 20c. Location - City of Town, State Josie Johnson / Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 04/28/2009 Baltimore, Maryland 22. Name and Address of Facility The Derrick C. Jones F/H, P.A. 21. Signature of Funeral Service Licens 4611 Park Hgts. Ave., Baltimore, Maryland 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Cancer Non-Small una resulting in death) /Medical Due to as a consequence of): Examiner Disease Obstructive hronic Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner as the burial-trans Atrial Flutter and Due to (or as a consequence of): P.O. Box 68760. the attending physician pe Diabetes Melli Physician/Medical IF FEMALE nse 23b. Was decedent pregnant in the past 12 months? fyes, outcome of pregnancy

Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy for Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autoosy performe certificate 1 ☐ Yes 2 ☐ No 1 □Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To funeral 27, Manner of Death 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 1 Natural
2 ☐ Accident 5 Pending investigation r death. 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 1 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed Month, Day, Year)

APR 2 8 2009

Service A. Spark

4940

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2.0

D. Douglas Gilbert

Eastern

H0068789

Avenue

Baltimore

2009

21224

			For State of Maryland / De State of Maryland / De	epartment of l Certificate of		, ,	giene Reg. No. 🔿 🐧 (20 10100
	Physici		1. Decedent's Name (First, Middle, Last) Angela F. Janssen		2. Date of Dea	/ / /	3. Time of Death 11:00 a ^M	
da.	/Medic		4a. Facility Name (If not institution, give street and number)		or Location of Death	Whiii	4c. County of	Death
	Funeral		Joseph Richey Hospice 5. Social Security Number 6. Sex 7. Age (In yrs. last birth)		If Under 24 Hrs.	8. Date of Birtl		. Birthplace (State or Foreign
	Director		216-16-6342 1 □ M 2X F 84 Yr Usual Residence of Decedent	s. Months Days	Hours Min.	AUG 10	1924 M	aryland
arylanc	Show	'n	10a. State 10b. County 10c. City, Town of					10d. Inside City Limits 1 ☐ Yes 2 No
The M	r 28a-f	Director	MD Baltimore Halet 10e. Street and Number	10f. Zip Code			10g. Citizen of Wha	
ath wit	s 23a o	ral D	1820 Superior Avenue	212			US	A
5-0036 72 hours after death with the Maryland	nd Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matte event, the Medical Examiner must be notified at	/ Funeral	1 Never Married 2 Married 1 Yes 2 No	13. Was Decedent of H If Yes, specify Cub 1 □Yes 2 ▼No	an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	Black, \	American Indian, White, etc.
5-0036 72 hours aff	atural", cal Exa	ted by	3ALI Widowed 4 □ Divorced Year or Dates:	ecedent's Usual Occup			Specify: 16b. Kind of Busin	White
	han "n	Completed	(Specify only highest grade completed) ((Specify only highest grade completed) ((Specify only highest grade completed)	Rive kind of work done fe. DO NOT use retire	during most of work d)	,		·
	al Hygie other t rent, III	Be Co	17. Father's Name (First, Middle, Last)	LOLY WOL			Distill Maiden Surname)	ery
Maryland d 2 should be file	d Mental narked o natic eve	To E	John LaBarre		Naomi	Lowm		
	that 7 is trau		Regina Nitsch - daughter 19b. N 234	ailing Address (Street Kenwood	Avenue,	al Route Numbe Caton	r, City or Town, Sta sville,	MD 21228
S 1	± <u>a</u> ≥ 5			sposition (Name of crematory or other place		Date 1	20c. Location - Cit	
altin	Department of Important; If any Injury or once.		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee H. Williams	Crematory, 2 Cremation			Baltimor	
n a	9 E E 8		23a. Part 1. Enter the disease, or complications that caused the death. Do not	299 Frede	erick Road	l, Balti	more, MD	21228
Ph	ysician		shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition					Approximate Interval Between Onset and Death
//	Medical aminer		a. Que to (or as a consequence of)	of the	100			in a contract
	<u> </u>	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	OF 70	ie vire	as 1		1.2 years
; execute	and al-trans	Examiner	Cause (Disease or Injury that initiated events c					0
ox 68/60, certificate be executed	physician and s the burial-transit	dical	d					
oertifica	nding pl		IF FEMALE: 23b. Was decedent propert 23c. If yes, outcome of pregnancy				001.0.1	
J. BOX e death ce	the atter	Physician/M	in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	cy		23d. Date o Month	,
that the	detach	/ Phy	Part II. Other eignificant conditions contributing to death but not resulting in the	g underlying oµuse giv	en in Part I.	23e. Did to	bacco use contribu	te to the cause of death?
Kecords, he law requires t	en sigr	ted by	Suy Eggs Veixer Cava Al	110m 1208	77	1 🗆 Ye	es 2 No 3[☐ Probably 4 ☐ Unknown
Heco	e has be ge 2 sh	Completed	l l			24a. Was a autops perfori	sy prio	re autopsy findings available r to completion of cause of
VITAI ician: T	ertificate ctor, pa	Be Co	25. Was case referred to medical examiner?		26. Place of Deat	1 □ Yes	2 X No 1 □	Yes 2 □No
OT V Physic	rthis ce raldire	၉	1 ☐ Yes 2 ☐ No		4 LI Nursing Ho			Specify) Hos NC
SION tending	or: Afte	ation	1 Autural 5 □ Pending (Month, Day, Year) Inju 2 □ Accident investigation	y Wor	k? Yes 2□No	zod. Describe no	ow injury occurred	1
lor Att	Direct Direct	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office		28f. Location (Si City or Town	treet and Number on, State)	or Rural Route Number,
Hospita	To the Funds after beau. To the Funds after beau. Completely filled in by the funeral director, page 2 should be detached for use as	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the basis of my knowledge, do control of examination and/or and manner stated.	eath occurred at the til r investigation, in my o	me, date and place, opinion, death occur	and due to the o	cause(s) and manne	er as stated. due to the cause(s)
To the	To the comple	Med	29b. Signature and title of certifier	29c. Licens			9d. Date signed (N	1
			· /V	DI	2572	-	04/27/	2009
			30. Name and address of person who completed cause of death (Item 23a) (Tyl	i West R	odwood	8/120	+ 13al	4 M) 21201
	Stat Registra		31. Date filed (Month, Day, Year) 32. Registra's Signature	Land		-10		

DHMH 17 Rev 1/2001

09-02746 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Walter C. Jordan, III State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 1917 hrs Walter C. Jordan, III Medical Examine April 6, 2009 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Howard 7401 Assateague Drive Jessun If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Director 11/06/1970 Texas 461-65-2664 1 X M 2 36 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State any 10h County Yes 2 X No KY 28a-f show Franklin 23a or 28a-f shov notified at once. MD 21215-0036 d 2 should be filed within 72 hours after death with the Maryland Ith and Mental Hygiene. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 103 1/2 W. Madison 42134 Funeral 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. items must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 2 1 Never Married Married ori Yes White Widowed 4 X Divorced Yes Give Year Yes 2X No specify: Specify: or other traumatic event, the Medical Examiner ş 16a. Decedent's Usual Occupation (Give kind of work done 6b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 11 Truck Driver unknown 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) marked Be Walter C. Jordan, Jr. Sarah Turner 19a. Informant's Name/Relationship (Type, Print) Walter C. Jordan, Jr. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5803 Ingram Road --/Apt 2901 San Antonio,TX 72822 Father es I and 2 sof Health a 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a Method of Disposition Date Baltimore, Burial 2 crematory or other place) Cremation 3 Removal from State portant: Donation 5 X Other Specify: instate 22. Name and Address of Facility State Anatomy Board Signature of Funeral Service Licensee Ronald S. Wade, 655 West Baltimore Street, Baltimore, MD 21201 Plart I. Enter the disease, or combilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** een Onset and failure. List only one cause on each line /Medical Death a. Asphyxia Immediate Cause (Final disease) xamine or condition resulting in death) Due to (or as a consequence of): b. Hanging Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transi Physician/Medical UNPENDED AMENDED attending physician for use as the burial Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physici IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Day Year past 12 months' Pregnant at time of death Other (Specify) detached for Yes 2 No 9 Unknown a Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Probably 4 Yes 2 ✔ No 3 Completed phods 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? Yes 2 ✔ No No Yes 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 Other₄ Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene ဠ 1 Yes 28a. Date of Injury FOUND: 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject hanged self **FOUND** Natural 1 ✔ Yes 2 Pending filled in by the Apr 6, 2009 1910 hrs Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 V Suicide Could not be or Town, State) 7401 Assateague Drive, Jessup, MD (Specify) Parking Lot in Vehicle Homicide 29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b. Signature and trife of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. April 7, 2009

State Registrar

ORIGINAL

111 Penn Street, Baltimore, MD 21201

31. Date filed (Mo

Melissa Brassell, MD

2

OCME

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #5, per Fh 98904/28/09 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** JOHN KELLY 51,55AM 04 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Tutherville Baltimore College Manor Nursing Home
Social Security Number 6. Sex 7. Age (In yrs. Ia Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) 217-22-1990 **Funeral** 1**∑**M 2□F Months Days Hours 82 08/25/1926 Maryland Director 217-221990 death with the Maryland 10d. Inside City Limits 10c. City, Town or Location show 10a, State 10b. County r 28a-f show notified at 1 ☐ Yes 2 XNo Director Baltimore Maryland Randallstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ms 23a or 7 21133 U.S.A. 3906 Susanna Road Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 X Yes 2 No 1945 If Yes, Give Year or Dates: 194 14. Race - American Indian, 7 is marked other than "natural", or items traumatic event, the Medical Examiner mo Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1945 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☑ Married altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: Black 1947 ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Custodian School System 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 Arthur Kelly Betty Jackson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3906 Susanna Road, Randallstown, Maryland 21133 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important; if item 27 is any injury or other trau once. Thomas Kelly / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Carrison Forest Ceme. 05/05/2009 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Owings Mills, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility The Derrick C. Jones F/H, P.A. 21. Signature of Funeral Service Licensee 4611 Park Hgts. Ave., Baltimore, Maryland 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final LARYNON **Physician** Methyantic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23h. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) ed by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CARDIOVAS CULAR 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 XNatural 2 Accident 5 ☐ Pending investigation 1 Yes 2 No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 0059107 04-27-2009 MiD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 210 BUNNESS CENTER DRIVE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month 2009 MARION O. KOROS /Medical 4c. County of Dea 4a. Facility Name (If not institution, give street and number) 4b. Qity, Town, or Location of Death Examiner Anne Bur BALTIMORE WASHINGTON MEDICAL CENTER 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Min, Months Days Hours 1 □ M 2√7 F Director 213.26.4147 DEC. 16, 1930 MD Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2√XNo Director MD ANNE ARUDEL GLEN BURNIE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with t arent of Health and Mental Hygiene.
The filem 27 is marked other than "natural", or items 23a or 2 and 14 filem 27 is the marked other than "natural", or other traumatic event, the Medical Examiner must be not 305 OXFORD DR. USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🕅 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐**xNy**o Specify: Specify: 9 WHITE 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 CROSSING GUARD ANNE ARUNDEL CO. SCHOOLS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be GEORGE ULLRICH LILLY MAE STOKES 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important; If item 27 is any Injury or other trai DONNA STRAMELLA DAUGHTER 1636 BEAR PAW LN., HANOVER, MD 21076 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State GLEN HAVEN CEMETERY APR. 25, 2009 GLEN BURNIE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility FINK EUNERAL HOME, P.A. 21. Signature of Funeral Service Licens GREGORY M01148 426 CRAIN HWY. S., GLEN BURNIE, MD 21061 Approximate Interval Between Onset and Death 23a. Part1 Enter the disea shock or heart falure Implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest by one cause on each line. Immediate use (Final disease or condition resulting in deal 100 Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a compaquence of): Examiner Due to (or as a consequence of) 68760, physician the burial Physician/Medical death certificate ending p Box IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy atte for u in the past 12 months? 1 ☐ Yes 2 ☐ Mo Month Day Year 5 ☐ Other (specify) the o 9□Unknown 9 Unknown signed by the Δ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 700 67 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an page 2 s autopsy 1☐ Yes 2 or Vital Physician; 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 ☐ Yes npatient 2 ER/Outpatient 3 □ DOA Certification: To After this funeral 28a. Date of Injury 27. Manper of De th 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? or Attending 5 ☐ Pending investigation Division (Month, Day Year) Injury Natural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director;
completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signatur and title of certifier 29c. License number 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 30 GO Bi 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last)

John Joseph Kaifer 2. Date of Death April 22 april 2009 ear **Physician** 1:03 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Charlestown Retirement Center Baltimore Catonsville If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 19, 19) 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** .^{Yea}1919 Months 89 217-22-2388 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City. Town or Location 10a State 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 717 Maiden Choice Lane 21228 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 White Completed by 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manager Seagrams Distillery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Conrad Kaifer Catherine Fuchs ျှ 19a. Informant's Name/Relationship (Type. Print)
Catherine Barth - Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6337 Redhaven Rd., Columbia, MD 21045 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 ☐Removal from State oudon Park Cemetery 4-27-2009 Baltimore, MD 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** accinoma disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 9□Unknown Month Year Day 5 ☐ Other (specify) signed by the a Id be detached f □Yes 2□No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>^</u> 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No certificate has the rector, page 2 s performed? 2 No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4☐ Hursing Home 5 ☐ Residence 6 ☐ Other (Specify) P 1 □ Yes 2 No 1 | Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1. Natural 5 Pending ours after death.
neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier フィング 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hod (928,5 (avo Maide (hoice 31. Date filed Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 2009 10, 10:53 AM April George A. Kress /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 2035 Bear Ridge Road #2 Dundalk If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1√2 M 2□ F Hours Min. Months Days 55 216-66-4142 Director 12/15/1953 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show traumatic event, the Medical Examination must be notified at 1 ☐ Yes 2X No Director MD Baltimore Dunda1k 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number ŏ 23a 2035 Bear Ridge Road 21222 USA Funeral items 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 24 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, Italy Audical Exartance and any injury or other traumatic event, Italy Audical Exartance and ☐Yes 2 Yes, Give 14 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🗵 No Specify: ģ Specify: 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Minnie Viola Richardson Stephen Thomas Kress 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Joanne Matthews Friend 2035 Bearridge Rd. Apt #2, Dundalk, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Fundal Service Lice Director 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street, Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Duse (Final disease or condition resulting in death) Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) □Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 🕾 Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Yes 2 8 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 30. Name and address of perso Date filed (Month, Day, Year State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #18 Per FH G890 4/28/09 JH State of Maryland Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** LEV 25 Day 2009 Year KAGANOVSKY APKTL 9:35A M /Medical ta. Facility Name (If not institution, give street and number)
SEASONS HOSPICE AT NORTHWEST HOSP. 4b. City, Town, or Location of Death RANDALLSTOWN **Examiner** 4c. County of Death BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. FEB 0018, Day 1928 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funera! Months 1 MM 2□ F 81 UKRATNE 215-92-2687 Director Usual Residence of Decedent 10a State 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Martical Eximiner must be notified at any injury or other traumatic event, If a Martical Eximiner must be notified at 10h County 10d. Inside City Limits Director MD BALTIMORE OWINGS MILLS 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8010 VALLEY MANOR ROAD 21117 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 1 No Specify: à Specify: WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **MANUFACTURER** EYE GLASSES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ANATOLY KAGANOVSKY MARLA Maria UNKNOWN ഉ NONA TRUTS I / DAUGHTER - IN-LAW 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 109 OLD PLANTATION WAY BALTIMORE, MD 21208 Baltimore, 20a. Method of Disposition
1 □ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of BAmala MORREOR) DEBRE (Place) 4/26/2009 20c Location - City or Town, State REISTERSTOWN, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** wow disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CRN12005dy 16005 if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) ed by the a 1 ∏Yes 2 ∏No 9 Unknown signed be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autonsy performe 1 □ Yes 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' 1 Yes 2 No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1\ Natural 5 Pending after death. 2 Accident investigation 1 ☐Yes 2 ☐ No filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours a 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier completely (Check only one) within 2 To the I 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month. Day. Year) 30. Name and address of person who completed cause of death (Item 31. Date filed (Month, Day, APR 28 32. Registrar's State 2009 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | 1 | 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 Month Victor Lensky April 26, 12:45 A.M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Lorien Mays Chapel Timonium Baltimore County 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) Months Days Hours M 2 □ F 95 Yrs. 294-32-6526 April 04,1918 Moscow, Russia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Maryland Baltimore County Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12230 Roundwood Road 21093 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 04 Inspector Ford Motor Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ivan Lensky 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen Fried (Daughter) Bailiffs Court #101 Lutherville,MD. 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State April 28, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Evans Funeral Chapel Forest Hill, Maryland 2009 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility eaceful Alternatives Funeral&Cremation Ctr.,P.A. 2325 York Road Timonium, Maryland 21093 23a. Part1 fn shoot, or ise e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ill re. List only one cause in each line. Approximate Interval Between Onset and Death Immediately aurie (Final disease or condition omplication disease or condition resulting in death) ucons Due to (or as a consequence of): Sequentially list conditions, if they leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Day time of death 5 Other (specify) not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No performed' 26. Place of Death (Check only one) nt 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital Describe how injury occurred j ation

hysician /Medical Examiner Examiner The law requires that the death certificate be executed by Physician/Medical

P.O. Box 68760

Division or Vital Records,

the Hospital or Attending Physician:

within 24 hours after death

To the Funeral Director:
completely filled in by the

within 2

Physician

Examiner

Funeral

Director

nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar artment of Health and Mental Hygiene.
ortant: If item 27 Is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is m any Injury or other traum

Baltimore, Maryland 21215-0036

/Medical

Director

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Completed

Be

the attending physician and hed for use as the burial-tran signed by the a d be detached f certificate

Completed

Be

2

Certification:

Medical

1 ∐ Yes 2 □ No 9 □ Unknown	9□Unknown
Part II. Other significant conditio	ns contributing to death but

2	5. Was case referre examiner? 1 ☐ Yes 2 ☐ 1	
2	7. Manner of Death	
	1 Natural	5 ☐ Pending investig
1	2 Accident	investig

 1 Inpatient 2	ER/Outpatien
28a. Date of Injury (Month, Day Year)	28b. Time o Injury

		. —	. ranoning i	OIIIO
28c.	Injury at Work? 1 ☐ Yes	2	□No	28d.

3∐ Suicide 4 ☐ Homicide	determined	28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Roll City or Town, State)					
9a. Certifier 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated								

nth, Day Year)	Injury	М	Work? 1 ☐ Yes	2 □ No	
e of injury - At he	ome, farm, stree	t, factory	, office		

28f. Location (Street and Number or Rural Route Number City or Town, State)

Balto, MD 2120

29b.	Signature	and	title	of coeffier
		٢		111
		/	_	

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Dav. Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6565

28

N. CHARLES ST. 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar		State of	iviai yiai	-	rtificate of l		,	Reg. No. 2	ng	13488
	Physic		1. Decedent's Name Justeen	(First, Middle Fa	•					2. Date of Dea	Day	Year	3. Time of Death
and a	/Medi Examir				give street and numb	er)		4b. City, Town, or	Location of Deat	April	26 200 4c. County		7:00 p ^M
Jap.			2905 Brie			A (1		Bowie	If I had as Od I has		Prince		
	Funeral Director		5. Social Security Nul. 236–30–19	98	6. Sex 1 □ M 2 🕱 F	Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da MAR 8	1927	Coun	lace (State or Foreign try) Virginia
	land ow		Usual Residence of D 10a. State	Decedent 10b. County		10c. Cit	ty, Town or Lo	cation				10	0d. Inside City Limits
	e Mary sa-f sh tified	ctor	MD 1	Prince	George's	Во	wie						1 ☐Yes 2X No
	vith the	Dire	10e. Street and Numb		т			10f. Zip Code			10g. Citizen of W		try?
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21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show with jnjury or other traumatic event, the Medical Evantine is ust be notified at once.	by	1 ☐ Never Married		Armed Force 1 Tyes 2 If Yes, Give Year or Date	No		Was Decedent of Hi If Yes, specify Cuba 1 □Yes 2 ½ No	n, Mexican, Puert Specify:	o Rican, etc.)	Specify:	k, White, e	etc.
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Baltimore,	permit Depart Import any In	9 4	21. Signature of Fund	eral Service I	even H. W	illiam	s Ĉ	Name and Address remation 99 Freder	s of Facility Society	of Marvl	and. In	C.	
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10 10	inding Phy ath. r: After this ie funeral d	ation: To	1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident	5 Pending investiga	28a. Date of I (Month,		ER/Outpatien 28b. Time of Injury	28c. Injury Work	y at 28d. Describe how injury occurred)
	To the Hospital or Atter within 24 hours after der To the Funeral Directo completely filled in by th	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could no determin	t be ed 28e. Place of building,	Injury - At ho etc. <i>(Specif</i>)	me, farm, stre	eet, factory, office		28f. Location (S City or Town	treet and Numbe n, State)	r or Rural	Route Number,
	n 24 hour n 24 hour ne Funer oletely fill	Medical (29a. Certifier 12 (Check only one) 2	Certifying Medical E	Physician: To the be kaminer: On the basis and manner	s of examina	wledge, death tion and/or inv	occurred at the tim vestigation, in my op	ne, date and place pinion, death occu	, and due to the or rred at the time, o	cause(s) and mar late and place, a	nner as st nd due to	ated. the cause(s)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. #23aSPare of War Rand Ade Sanne Hof Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Millie S. /Medical April 2009 7:40 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗙 F Months Days Director 220-14-6545 93 8-17-1915 SC Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatih and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It is Medical Examinan must be natified at Director XXYes 2 □ No MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2543 W. LANVALE STREET 21216 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: þ Specify. 3 Widowed 4 □ Divorced BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 HOUSEKEEPING CATHLIC SCHOOL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CHARLIE STEWART LUCY JOHNSON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EMMA S. BROWN/SISTER 8646 ELEVENTH AVE. SILVER SPRING, MD 20903 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State ARBUTUS MEMORIAL PK. 4-29-09 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MD 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 21. Signature of Funeral Service Licensee 1701-31 LAURENS ST. BALTIMORE, MD 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Pre Renal Azotemia Immediate Cause (Final **Physician** lina disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? s been signe should be c Completed by 1 ☐ Yes 2 1 1 1 1 3 ☐ Probably 4 XXnknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an certificate has birector, page 2 s 2 No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day, Year) After th funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

o ۵. Records, Division of Vital To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director; After th completely filled in by the funeral

Baltimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier (Check only one)

> Jason Black 6565 Norm Charles St, Suite 209, Touson MO 21204 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D0061199

29d. Date signed (Month, Day, Year)

April, 23, 2009

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Vear **Physician** mer 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Baltimore Medical Center If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1**X** M 2□ F Director 68 1940 216-36-7809 JULY 26, MD Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov Injury or other traumatic event, the Medical Examir or must be recified at Director 1 Yes 2 No BALTIMORE DUNDALK MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21222 1708 DUNDALK AVE. USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 2 1 ☐ Yes 2 ☐ No Specify. Specify 3 Widowed 4 Divorced BLACK Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 TIN MILL LABORER BETHLEHEM STEEL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be fi Health and Mental I ELMER LOMAX, SR. VERNICE GREEN ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FREDERICK LOMAX/BROTHER 1708 DUNDALK AVE. APT. C2 BALTIMORE, MD 21222 20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Stanislasus Cemeters

OLY THE TENSOR 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or ot 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4-30-2009 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 21. Signatore of Funeral Service Licensee 1701-31 LAURENS ST. BALTIMORE, MD 21217 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or s a consequence /Medical Examiner Leumonio Sequentially list conditions, if any, leading to himmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last APPROVED BY MEDICAL EXAMINER Examiner certificate be executed Aspiration

Due to (or as a consequence of): and burial-trar CERTIFICAT Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas page 2 autopsy cate ! perform 1 □ Yes 2 No 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 □KYes 2 X 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this (funeral dir Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 Natural hours after death. 1 ☐ Yes 2 🗌 No 2 Accident To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Eastern Miller Baltimore, MD 21221 Avenue 31. Date filed (Month, Day, Year) 2. Registrar's Signature State APR 2820 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** ing Hoon 40211 2009 /Medical Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner ALTIMORE WASHINGTON MEDICAL ILEA BURNIE Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number **Funeral** Months Days Hours 1 M M 2 □ F 212-19-9006 Director Usual Residence of Decedent 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits 28a-f show Department of Health and Mental Hygiene. Important; in items 23a or 28a-f show important; if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examination at Director 1XYes 2 ☐ No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number KOREA 7983 10 by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 □Yes 2 ► If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2 No Specify. 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) TECH NICIOAN 18. Mother's Name (First, Middle, Maiden Surname) Be (17 Father's Name (First, Middle, Last) LEE BEK NYUN CHOI SOOL ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) GLEN BURNIE, MY ZIOGI VIVG 0 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 Burial 2 □ Cremation 3 □ Removal from State 129/09 GLEN BURNIE MID 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lic Facility / HOWELL 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last and burial-tran Due to (or as a consequence of): P.O. Box 68760, After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physi completely filled in by the funeral director, page 2 should be detached for use as the templetely filled in by the funeral director, page 2 should be detached for use as the templetely filled in by the funeral director, page 2 should be detached for use as the templetely filled in by the funeral director, page 2 should be detached for use as the templetely filled in by the funeral director, page 2 should be detached for use as the templetely filled in by the funeral director, page 2 should be detached for use as the templetely filled in the filled in the funeral director. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 Mo Month Dav Year 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 2 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an autopsy performed? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 npatient 2 ER/Outpatient 3 DOA Certification: To Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of eath 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0032

State Registrar

31. Date filed (Month, Day,

30. Name and address of decision who completed cause of death (Item 23a) (Type, Print)

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of De egaluppi Month April Day 26 Physician LUCIANA M DISS /Medical 4b. City, Town, or Location of Death 4c. County of Death
BAITMORE 4a. Facility Name (If not institution, give street and number) Examiner 8301 Thorston MD 20 2D If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country)
Italy 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 □ M 2 F Months Days Hours 216-80-9129 12-16-1935 73 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h County 10a. State show or than "natural", or items 23a or 28a-f show 1 ☐ Yes 2 X No MD Director Baltimore Towson 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8301 Thornton Road 21204 U.S.A. Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 TNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: Specify: White ģ 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 10th permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item Z7 is marked other any injury or other trainmatic. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Assunta Venanzi Giuseppe Romani 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Son Francesco L. Legaluppi 1106 W. Joppa Road Baltimore Co. Md. 21204 Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5-2-2009 Timonium, Maryland Dulaney Valley 4 □ Donation 5 □ Other (Specify) Entomb 21. Signa f Funeral Service Licensee 22. Name and Address of Facility Joseph N. Zannino Jr. F.H. 263 S. Conkling Street Balto. MD. 21224 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death akin sonis Immediate Cause (Final disease or condition resulting in death) DISPACE YEARS **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): certificate be executed burial-tran and Due to (or as a consequence of): Box 68760. attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) P.O. | 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 □ Yes 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has 1 ☐Yes 2 No director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Desidence 6 Other (Specify) 1 ☐ Yes 2 🕠 № 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral c 28a. Date of Injury (Month, Day, Year) To the Hospital or Attending Pt within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

29b. Signature and title of certific



29d. Date signed (Month, Day, Year)

APRIL 27, 2009

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Physician Delores Mary Leland 2009 8:10 p April 23 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner **Baltimore** Lorien Rehab Ctr. Timonium 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 □ KF May 22 MD 93 1915 Director 212-10-4168 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If Item 27 Is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinations to notified at 1 □Yes 2 □No Director Cockeysville MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 46 Gibbons Blvd. 21030 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 □Yes 2 ★ lo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify Specify: white ģ 3 XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 12 n/a 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Flury John Schlee 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 46 Gibbons Blvd., Cockeysville, MD 21030 Patrick R. Leland/son 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages
Department of
Important: If It
any Injury or o 4/27/09 New Cathedral Cem. Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Signature of Funeral Pervice Licenses Lemmon Funeral Home of Dulaney Valley, Inc. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final BAYS **Physician** disease or condition resulting in death) /Medical Examiner ADJULT FAILURE TO THRIVE MONTHS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Feta! death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Day 5 ☐ Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural
2 Accident Injury 5 Pending ours after death. 1 ☐ Yes 2 ☐ No investigation 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D64395 APRIL 24, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DANIEUE DOBERMAN, MO 6565 NORTH CHARLES ST, SUITE 209 BALTIMORE, MD 21204 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 5:17 PM APRII 24,2009 Sharon Sue Lindsay /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE SAINT AGUES HOSPITAL N/A 9. Birthplace (State or Foreign Country) West Virginia If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Funeral 1 □ M 2 💢 Days Hours 1948 60 Jun. Director 214**-**52**-**8567 Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland nand Mental Hygiene.
Is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural"; or Items 23a or 28a-f show ampliant or other traumatic event, I'm Medical Evarimer is until to notified at once. Lansdowne Baltimore 1 ☐ Yes 2 TXNo MD Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21227 United States 2218 Smith Avenue 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 XNo 11. Marital Status 1 XNever Married 2 Married Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Records Examiner 12 Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Melvin U. Lindsay Virginia Pearl Robey ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2218 Smith Avenue, Lansdowne, MD 21227 Melvin U. Lindsay - Father 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Nation 2 □ Cremation 3 □ R 4 □ Domation 5 □ Other (Specify) 3 Removal from State Cedar Hill Cemetery 4-28-2009 Brooklyn, MD 22. Name and Address of Facility Ambrose Funeral Home, Inc. Signalule of Fun, ral Servic L cens 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 2 DAYS SEPSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or light) that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? perform certificate 2 MNo 1 □Yes Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral D 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier P 20656 APRIL 24, 2009

DHMH 17 Rev 1/2001

State Registrar

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ORIGINAL

900 CATON AVE. BALTIMORE MD 21229

30. Name and address of person who completed cause of ceath (Item 23a) (Type, Print)

Registrar's Signature

KONSTANTIN ZUBELEVITSKIY

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

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Division of Vital Records, P.O. Box 687

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	imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 h ment of Health and Mental Hygiene. Tant: If item 27 is marked other than "n or other traumatic event, the Medical E.	To B	Thomas Francis LePore 19a. Informant's Name/Relationship (Type, Print)	1	19b. Mailing	Address (Stre	eet and Number o				
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	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	cai	Check only one) 2 Medical Examiner: On the best								
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	φ		 Name and address of person who completed cause Russell Alexander MD. Assistant Me 	of death (Item 23a edical Examine	•	Penn Street	t, Baltimore, I	MD 21201			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** Joseph F. Messina, Jr. APRIL 2009 3:30 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Saint Joseph Medical Center Baltimore Tawsan If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Months 1⊠M 2□ F 89 215-14-0532 Director 04/20/1920 Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Medical Exeminer must be notified at Baltimore Parkville 1 ☐ Yes 2 No Director MD 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 3024 Edgewood Avenue 21234 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give WWII Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status o 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 No Specify: White þ 3 X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry
Eastern Stainless 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 72 d 2 should be filed within the and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Steel Electrician 11 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Joseph F. Messina, Sr. Catherine Virginia Petarro 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sl Department of Health an Important: If Item 27 is n any injury or other traun 500 Queensbury Court, Fallstons, MD 21047 Timothy Messina/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Loudon Park
Cemetery 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 04/30/09 Catonsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services 8800 Harford Rd. Parkville, MD 21234 21. Signature of Funeral Service, Licensee Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Inimpliate Cause (dis se or condition resulting in death) **Physician** PNEUMONIA /Medical Due to (or as a consequence of): **Examiner** ACUTE RENAL FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off: certificate be executed and burial-trar Due to (or as a consequence of): attending physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ſοι in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) the 9 Unknown 9 Unknown Ś Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an has page 2 autopsy performed Yes 2 certificate 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Hospital or Attendi 24 hours after death. Funeral Director: A filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Box 68760.

P.O.

Records,

Division of Vital

Registrar DHMH 17 Rev 1/2001

State

MESSINA

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JOGINDER 1 31. Date filed (Month, Day,

ORIGINAL

mello

7601

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

P 231340

D41410

Osler Drive, Towson,

200

Maryland 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

rian Steven Mo		1- For State	te of Maryla			of Health of Death	and M	/lental l		Reg. No.	2	009	1349		
Physicia ledical Examir	in/	Registrar 1. Decedent's Name (First, Middle,	Brian			Morris	 S		2. Date of Do Month April 25,	eath Day	Year		of Death 0 hrs		
		4a. Facility Name (if not institution, 17 Kelly Avenue	give street and num	nber)		4b. City, Tow Bel Air	n, or Loca	ation of Dea		4	c. County of Harford	Death			
Funeral Director			Sex 7	7. Age (In yrs. I	20			f Under 24H Hours M				Birthplace Foreign Country)	State or PA		
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Heathh and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-5 sho injury or other traumatite event, the Medical Examiner must be notified at nece	Be Con	17. Father's Name (First, Middle, L Scott Do	ouglas	Morri	<u> </u>		18.N		me (First, Middle		Surname)	уе			
MD 21 d 2 should Ith and Me n 27 is ma	욘	19a. Informant's Name/Relationshi Kathy Morris, n			132	iling Address (p R	d.	Jarret	tsv	ille,	MD 2	1084		
MOre, Pages 1 an nent of Hea ant: If ite		20a. Method of Disposition 1 Burial 2 X Cremation 4 Donation 5 Other Spe	cifv:	m State Me	crematory o	position (Name or other place)			Date 4/27/09	-		Dity or Town, S			
Balti permit. Departn Importi injury o	1	21. Signature of Funeral Service L	censeeGeorge			2. Name and Ad 299 Fre	ederi	ick Ro	oad 1	Balt:	imore,	MD 2	1228		
Physician /Medical xaminer	Examiner	23a. Part 1. Enter the disease, or confailure. List only one cause of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	n each line. Co a. Hydromo Due to (or as a of the control of the	mbined rphone) consequence of conseq	Drug) Into	(Diphen	hydra	amine	, Cocai	ne,		Betw	oximate Interval reen Onset and Death		
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate b within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the but	š	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unkn	1 Live bit	ant at time of de	2	Fetal death Other (Specify		Ectopic preg	gnancy	23	Nonth	elivery Day	Year		
P.O. I	ξ	Part II. Other significant condition	ns contributing to	death but not r	esulting in t	he underlying ca	use giver	n in Part I.				ute to the cau	se of death? Unknown		
Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been silled in by the funeral director, page 2 should be	Completed									topsy rform <u>ed</u> ?	pri de		ndings available on of cause of		
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Division of Vital F Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifitely filled in by the funeral director,	\vdash	27. Manner of Death 1 Natural 5 Pendir 2 Accident Investi	gation 4-25-	Day,Year) 09	28b. Time 6:51	. pm 1		2 X No	28d. Describ		jury occurred	d			
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To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Exam	rsician: To the best iner:On the basis of and manner sta	f examination a		tigation, in my op	oinion, dea	ath occurre		ite and p	ace, and du	e to the cause			
	2	29b. Signature and title of certifier Theorbre M.	King J	Rym	id.		ocense nu D.C.M.E	DI	CME		ril 26, 200	d (Month, Day 09	r, rear/		
		30. Name and address of person w Theodore M. King, Jr.,	MD. Assistar	nt Medical E	Examiner		Street	t, Baltimo	ore, MD 212	01					
Sta Regist	ate rar	31. Date filed (Month, Day Year) APR 282	009 38 Rec	gistrar's Signar	* A	wed									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death **Physician** Month Day Year JUNE MCGRAIN /Medical 25, 2009 12:15 April 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death St. Joseph's Nursing Home Catonsville Baltimore Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) JUN 17 1918 9. Birthplace (State or Foreign **Funeral** Months 1 ☐ M 2 🔀 F Days Min. Hours 216-01-4344 90 Maryland Director Usual Residence of Decedent 10a. State 10c. City, Town or Location ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits Director 1 □Yes 2 No MD Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7892 Bastille Place 21144 USA Funeral hours after death Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No 2 Specify. Specify: White 3X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry within 72 l (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 10 College (1-4or 5+) Homemaker d 2 should be filed v h and Mental Hygie 7 Is marked other tl Own Home permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 Is marked othel any injury or other traumatic event, i 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be F. 0'Toole John P Catherine Μ. Panuska 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy M. Murphy - daughter 3139 Blackberry Lane, Prince Frederick, MD 20678 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Crownsville VA Cem. 04/30/2009 Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service ticenseen, H. Williams ²²MacNabb Funeral Home, P.A. 301 Frederick Road, Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Athero scheenc Physician Cardiovascu /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examine certificate be executed and burial-tra Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery The law requires that the death 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 Tes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2: autopsy perform certificate 2 No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4XNursing Home 5 Residence 6 Other (Specify) 2**X** No Hospital: 1 🗌 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Medical Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Division or Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: " within 24 hours after death. To the Funeral Director: After this certifical within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

> State Registrar

DHMH 17 Rev 1/2001

29a, Certifier

29b. Signature and title of certifier

yotin 31. Date filed (Month, Day,

Eutaw St. Ste 407, Baltimore Jag 821 Ni MD 28 2009

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D32158

29d. Date signed (Month, Day, Year)

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	Physic /Medi		Decedent's Name (First, Middle, Last Decedent's Name (First, Middle, Last		Griffin Mo	sley		2. Date of Death Month	r 16, 2009 Year	3. Time of Death	
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Apple.	Funeral Director		219-07-7103	7. Age	90 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Mar 13,	9. Birt (ear)	hplace (State or Foreign (Intry) Maryland	
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	with the N a or 28a-f	Director	10e. Street and Number 2327 North Charles Street			10f. Zip Code	21218	10	g. Citizen of What Co	untry?	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 🗷 Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 🔯 N If Yes, Give Year or Dates:	0	Was Decedent of Hi f Yes, specify Cuba I □ Yes 2 No		ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	rican Indian,	
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Itimore	permit. Pages 1 Department of He Important: If iten any injury or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Europe Service License		Garrison For	rest Veterans	Cemetery	Date 20 04/28/09	Oc. Location - City or Owings N		
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DIVISION OF VIT	this ald	Certification: To Be	25. Was case referred to medical examiner? 1 Yes 2 He 27. Manner of Death 1 Actural 5 Pending investigation 3 Suicide 6 Could not be determined	ospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day) 28e. Place of injury building, etc.	28b. Time of Injury	3 DOA Other 28c. Injury Work? M 1 Y	at 2 No	me 5 Residence	t and Number or Run		
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)	Tot withi Tot		29b. Signature and title of certifier	mmo		29c. License	3510	29d. Z_ A	Date signed (Month,	Day, Year) 2009	
	Stat Registra	te	30. Name and addless of person who cor 11 W 1 DON N 31. Date filed (Month, Day, Year) APR 28 200	npleted cause of dea	th (Item 23a) (Type, P	h CHA	ulus St	rut Be	1 (fimore	Maxy lang	
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